



Australian  
Human Rights  
Commission

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# Use of force in immigration detention

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[2019] AusHRC 130

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# Use of force in immigration detention

[2019] AusHRC 130

*Report into the use of force in  
immigration detention*

**Australian Human Rights Commission 2019**



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**Australian  
Human Rights  
Commission**

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The Hon Christian Porter MP  
Attorney-General  
Parliament House  
Canberra ACT 2600

Dear Attorney

I have completed my report pursuant to s 11(1)(f) of the *Australian Human Rights Commission Act 1986* (Cth) into the issue of use of force in immigration detention and in transfers to and from immigration detention.

The issue of the use of force in immigration detention has been raised in a range of complaints against the Department of Home Affairs received by the Commission. This report deals thematically with 14 complaints.

In relation to nine of the complaints, I found that there was a use of force that was contrary to the requirements of article 10 of the *International Covenant on Civil and Political Rights* (ICCPR). This article provides that all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person. Some of these complaints related to the use of handcuffs. In one case, handcuffs were applied to a detainee for 8 and a half hours over a significant wrist wound while he was transferred between detention centres.

In one of these complaints I also found that the conduct of male Emergency Response Team officers, when they entered the bedroom of a young woman aged 19 years old unannounced and refused her the opportunity to get dressed without them being present, was contrary to her right to privacy under article 17(1) of the ICCPR.

In another of these complaints, I found that the separation of a mother from her husband and new born baby daughter for 32 hours was contrary to the daughter's rights under article 9 of the *Convention on the Rights of the Child*, and the refusal to allow the mother access to legal advice during this period was contrary to the mother's rights under article 10 of the ICCPR.

In relation to the remaining five complaints, I did not find that a breach of human rights had been established.

I made recommendations aimed at remedying the loss or damage caused by the breaches of human rights. I also made a range of systemic recommendations aimed at reforming the way in which force is used in immigration detention.

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The department provided its response to my findings and recommendations on 2 April 2019. It did not agree that any of the conduct complained of involved a breach of human rights. Nevertheless, it noted that since receiving my preliminary views in this inquiry it had made amendments to its internal policies which were directed to many of the issues that were the subject of my recommendations. The department also said that it would take further action in the future to implement other recommendations in this report.

I have set out the department's response in Part 13 of this report.

I enclose a copy of my report.

Yours sincerely,

A handwritten signature in black ink that reads "Rosalind Croucher". The signature is written in a cursive, flowing style.

Emeritus Professor Rosalind Croucher AM  
**President**  
Australian Human Rights Commission

May 2019



# 1 Introduction to this inquiry

1. The Australian Human Rights Commission has conducted an inquiry into the issue of use of force in immigration detention and in transfers to and from immigration detention. This is a thematic inquiry, based on a number of specific complaints, that draws together observations about how force is used in a variety of different circumstances. The aim is to provide a foundation for systemic practical outcomes for people who are in immigration detention in Australia. The inquiry was undertaken pursuant to s 11(1)(f) of the *Australian Human Rights Commission Act 1986* (Cth) (AHRC Act).
2. The issue of the use of force in immigration detention has been raised in a range of complaints against the Department of Home Affairs (the department) received by the Commission. This report deals thematically with a number of similar complaints. Examples drawn from particular complaints are used in case studies throughout this report.
3. The particular environment of immigration detention means that the use of force may occasionally be necessary. However, the use of force on detainees directly engages their rights. In particular, people who are deprived of their liberty have the right to be treated with humanity and with respect for their inherent dignity. For this reason, any use of force must be appropriately justified. There must be a legitimate reason for using force, for example, in order to protect the safety of others, and the degree of force used should be proportionate to that legitimate reason.
4. Given the significant impact on individual rights, any use of force must be necessary in the circumstances. Force should only be used as a measure of last resort. This means that available alternatives to using force, such as negotiation and de-escalation techniques should be employed and exhausted before there is a resort to force. Force should be used only for the shortest amount of time necessary. The degree of force used should not be excessive. Certainly, force should not be used for punishment or in a way that amounts to cruel, inhuman or degrading treatment.
5. When assessing if force is necessary, resort is sometimes had to risk assessments. This report considers the way in which these risk assessments are carried out. If risk assessments are not accurate, if they are not sufficiently tailored to the particular circumstances of the detainee, or if they are not sufficiently tailored to the particular circumstances in which the use of force is anticipated, it can result in force being used too readily. The Commission welcomes the fact that, following the commencement of this inquiry, the department has decided to review its Security Risk Assessment Tool.
6. There also needs to be effective oversight of the use of force. This starts with ensuring that there are clear lines of authority for approving the use of force, that specific approval is given for each use of force, and that records of such approvals are kept. Further, the actual use of force must be appropriately documented. The best way to do this is to ensure that any pre-planned use of force (and other uses of force to the extent possible) are filmed in their entirety. Reports on the use of force should be prepared to allow for subsequent review of whether it was appropriate.

7. This report is based on an inquiry into 14 separate complaints about use of force received by the Commission. It is not an overview of every allegation of use of force in immigration detention and the Commission has not sought information about specific instances of use of force beyond the particular complaints that it has received. The Commission does not suggest that the present inquiry amounts to a comprehensive survey of all instances in which force has been used in immigration detention. However, in the course of inquiring into these complaints, the Commission has sought information and documents about how similar cases are generally dealt with. Findings have been made in relation to each of the 14 complaints. The recommendations made in this report are based on these findings and the themes that emerge from a comparison of these complaints.
8. The inquiry primarily considers whether instances of use of force were consistent with the requirements of article 10 of the *International Covenant on Civil and Political Rights* (ICCPR) which provides that all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person. Similar obligations are contained in article 37(c) of the *Convention on the Rights of the Child* (CRC). The content of these rights is informed by other principles including the *Standard Minimum Rules for the Treatment of Prisoners* and the *Body of Principles for the Protection of all Persons under Any Form of Detention*.
9. Most of the complainants were, or are, asylum seekers and have sought protection in Australia. Some of the complainants have been removed from Australia since making their complaint. With one exception, I have made a direction under s 14(2) of the AHRC Act prohibiting the disclosure of the identities of the complainants and their family members in connection with their complaints. In this report, each of them has been given a two letter pseudonym. The one exception is Mr Sayed Abdellatif. Mr Abdellatif asked that his identity be made public. The Commission has previously reported in relation to a complaint made by him about his detention at Villawood Immigration Detention Centre where he remains detained (*Abdellatif v Commonwealth* (DIBP) [2014] AusHRC 70).
10. On the basis of this inquiry, I have made findings about the application of force in a number of individual complaints that can be grouped as being of the same kind. My findings in relation to these complaints are as follows.
  - (a) In cases dealing with the use of handcuffs when transferring people between immigration detention centres:
    - (i) Mr AY was required to wear handcuffs over a significant wrist wound for at least 8 and a half hours during a transfer between immigration detention facilities in Sydney and Perth. There are no records requesting approval for the use of handcuffs which explain why it was considered necessary to handcuff him and no records containing an approval for the use of handcuffs. There are no records that suggest that medical practitioners were asked for, or gave, any advice about whether Mr AY should be handcuffed for transport. There are no records that suggest that restraints were required by the captain of the flight. Two days after the transfer, Mr AY's skin was inflamed up to 20cm from his wrist and he was reporting significant pain. I find that the use of handcuffs in these circumstances contributed to Mr AY's pain and discomfort and was contrary to his rights under article 10 of the ICCPR to be treated with humanity and with respect for his inherent dignity.

- (ii) Mr BC was handcuffed after he physically resisted officers prior to boarding a plane from Darwin to Nauru along with his two sons. The captain of the flight asked that he be restrained and he was handcuffed for the duration of the flight. A log of the flight shows that the handcuffs were checked every 15 minutes. On the basis of the material provided to me, I am not satisfied that the level of force used was inappropriate in the circumstances.
  - (iii) Mr CE was required to wear handcuffs for more than 12 hours during flights between Christmas Island and Melbourne via Perth. His individual security assessment did not justify the application of restraints. The department has suggested that he was restrained, not because of the risk that he presented individually, but because he was being transferred with other detainees who required restraints. The department's response also suggests that force was used on Mr CE, at least in part, because he was Vietnamese (see paragraphs 170 to 171 below). I am not satisfied that the use of restraints on Mr CE was necessary and I find that the application of handcuffs for more than 12 hours was contrary to his rights under article 10 of the ICCPR to be treated with humanity and with respect for his inherent dignity. I am also concerned that Mr CE's ethnicity was a factor that was taken into account in the decision to restrain him.
- (b) In cases dealing with the use of handcuffs to travel to court and medical appointments:
- (i) Mr DB was required to wear handcuffs to attend a number of court appointments in relation to an alleged assault. Given that the allegation was one of violence, I am not satisfied that the requirement for mechanical restraints was inappropriate. However, there were process problems in seeking approval for restraints to be used. On two occasions, restraints were used prior to Serco receiving approval for their application. On another occasion, Mr DB was not medically cleared by International Health and Medical Services (IHMS) prior to restraints being used as there were no IHMS staff on site. Mr DB was ultimately acquitted of the charges.
  - (ii) A few months later Mr DB was again required to wear handcuffs in order to attend external medical appointments. Having considered in detail Mr DB's security assessments and the incidents he was involved in while in detention, I find that this requirement was not reasonable in the circumstances or proportionate to relevant risks. I am particularly concerned that there do not appear to be any documents that consider whether the requirement that Mr DB be restrained was appropriate given the medical risks that he faced if treatment was not provided. I find that the requirement that he be handcuffed to attend these medical appointments was contrary to his rights under article 10 of the ICCPR to be treated with humanity and with respect for his inherent dignity.

- (iii) Mr Sayed Abdellatif was required to wear restraints to attend medical appointments in October and November 2015. At the time he had a 'high' security risk assessment as a result of an alleged threat to staff. He refused to wear restraints and did not attend these appointments. The department subsequently reviewed and downgraded his risk assessment. On the material available to me, I am not able to be satisfied that the requirement that he be restrained was inappropriate.
- (c) In a case dealing with the use of a face mask during an attempted removal from Australia:
  - (i) Mr EJ was required to wear a face mask during an attempt to deport him to China on 19 December 2014. On the basis of the material provided by the department and Mr EJ, I am not satisfied that Mr EJ made any threat, whether direct or indirect, to bite or spit at escort staff. I find that the decision to authorise the use of a face mask on Mr EJ for his escort to the flight and, if necessary, for the duration of the flight from Australia to China, was disproportionate to any risk faced and was contrary to his rights under article 10 of the ICCPR to be treated with humanity and with respect for his inherent dignity.
- (d) In cases dealing with the use of force within immigration detention facilities:
  - (i) Force was used on Mr FE while he was detained at Christmas Island Immigration Detention Centre. I find that force was used on him in a situation where it was unnecessary. He had already been contained inside an accommodation block and officers opened the door and entered the room in order to use force on him. I am concerned about the application of downward force to Mr FE's head while it was in contact with the concrete floor. I find that this caused his implanted tooth to be dislodged. I find that these acts were contrary to Mr FE's rights under article 10 of the ICCPR to be treated with humanity and with respect for his inherent dignity.
  - (ii) Force was used on Mr GH to restrain him and escort him to an interview room. I find that this use of force was proportionate to the need to maintain good order at Maribyrnong Immigration Detention Centre. The use of force followed allegedly disruptive behaviour by Mr GH and a failure by him to voluntarily accompany officers to the interview room.
  - (iii) Force was used on Mr HF at the conclusion of an interview with him about the need for him to move rooms while he was detained at Maribyrnong Immigration Detention Centre. I find that the actions of Serco officers who had previously been interviewing him caused the situation to escalate into an avoidable use of force. I find that force was not used as a last resort and that other communication, negotiation and conflict de-escalation strategies could and should have been attempted. The failure to use force as a last resort was contrary to Mr HF's rights under article 10 of the ICCPR to be treated with humanity and with respect for his inherent dignity.
  - (iv) Mr JB was subject to a pat search during a search of his room. I find that the conduct of Serco officers in conducting a pat search of him was not inconsistent with or contrary to his human rights.

11. I have also considered complaints by four family groups about an operation in April 2015 during which force was used to remove 19 detainees from Wickham Point immigration detention facility and transfer them to detention facilities in Melbourne. In relation to these complaints, my findings are as follows:
- (a) In the case of the complaints on behalf of Mr KE, Mrs KF and their three children Ms KG, Master KH and Master KI:
    - (i) I find that flexi-cuffs and later mechanical handcuffs should not have been applied to Mr KE. This was a 46 year old father of three with a low security rating. Prior to April 2015 he had only one incident of 'aggressive/abusive behaviour' in 20 months of detention. He was a highly compliant detainee. The department's Detention Services Manual says that restraints should only be used on detainees who have a serious or violent criminal history, who have a history of escape or who potentially pose a high risk as indicated by their individual risk assessment. None of these criteria applied in relation to Mr KE.
    - (ii) I find that flexi-cuffs and later mechanical handcuffs should not have been applied to Mr KE's 17 year old son Master KH. This was a minor who did not have a history of violence and whose risk rating was medium. Relevant human rights principles provide that force should be used on children only in exceptional circumstances and where all other control methods have been exhausted and failed. There is no evidence that Master KH was given the option of walking cooperatively with officers to the muster area. Rather, it appears that flexi-cuffs were applied at the first available opportunity.
    - (iii) I am not satisfied that any disproportionate use of force was applied to Mrs KF or their other two children. However, I note that the display of force during the course of this operation was likely to be distressing for their 9 year old son, Master KI.
  - (b) In the case of complaints on behalf of Ms LC, her husband and their one month old baby daughter:
    - (i) Ms LC was escorted from her room to the muster area without the need for restraints but was then handcuffed for an hour and 40 minutes while being transferred from the detention facility to the police watch-house along with a number of other detainees. She was not charged with any offence. Detainees were merely held at the watch-house pending transfer to Melbourne the following day. Ms LC was separated from her husband and baby for 32 hours. Ms LC asked to speak with a lawyer and this request was denied. I find that this treatment of Ms LC was contrary to her rights under article 10 of the ICCPR to be treated with humanity and with respect for her human dignity, and with the rights of her baby daughter under article 9 of the CRC not to be separated from her mother.

- (c) In the case of the complaints on behalf of Mrs MD and her husband Mr ME:
  - (i) Mr ME did not have any history of abusive, aggressive or violent behaviour. He had only recently been returned to immigration detention after five weeks as an intensive psychiatric inpatient in a private hospital. At the time of the extraction of families from Wickham Point, his diagnosis was of a schizoaffective disorder, bipolar type. I am not satisfied that his mental health issues were sufficiently taken into account during the extraction. I find that the use of flexi-cuffs and mechanical restraints on Mr ME was not appropriate in the circumstances and was contrary to his rights under article 10 of the ICCPR to be treated with humanity and with respect for his inherent dignity.
- (d) In the case of the complaints on behalf of Mrs NL, her husband Mr NM and their three month old son:
  - (i) Ideally, Mrs NL would have been permitted to carry her son during the course of the extraction. It appears from the CCTV that Mrs NL was providing some resistance to the officers escorting her. The officers appear to use no more force than is necessary in the circumstances. As a result of the resistance given by Mrs NL, I am not satisfied that it was disproportionate for Serco to determine that she be physically escorted by two officers with a third officer in close proximity carrying her baby.

12. The complaint on behalf of Mr KE, Mrs KF and their three children Ms KG, Master KH and Master KI also raised issues in relation to arbitrary interference with privacy. In relation to this complaint, I make the following findings:

- (a) At least four masked ERT officers entered the bedroom of Ms KG, then aged 19, unannounced before dawn and refused her the opportunity to get dressed without them being present. Ms KG was not sharing this room with anyone else. Serco had assessed her as being a low risk detainee, including a low risk of becoming aggressive or engaging in self-harm. I find that the way in which this action was conducted was neither reasonable nor proportionate to a legitimate purpose. Alternative ways of proceeding were readily available that would not have involved this very significant interference with her privacy. For example, a female officer not wearing personal protective equipment (PPE) could have knocked on the door, announced who she was and entered the room alone to give Ms KG the opportunity to preserve her privacy. I note that a female officer, not wearing PPE, accompanied Ms KG's 9 year old brother as he was led through the corridors during the extraction. I find that the conduct of the ERT officers in this situation was contrary to Ms KG's right to privacy under article 17(1) of the ICCPR.

13. These particular incidents, along with the Commission's experience in inspection of places of immigration detention, raise a number of systemic concerns. In particular, I am concerned about the following issues.

#### Risk assessments

- (a) Changes to Serco's security risk assessment tool (SRAT) in April 2015 mean that certain classes of people were deemed to be high risk, regardless of their individual circumstances. For example initially all physically fit single adult detainees were required to be restrained during all escorts in the first 30 days of their detention. While the position has been modified since then, the current position still involves treating some people as high risk regardless of their actual level of risk.
- (b) I am concerned that the SRAT may not be sufficiently nuanced to avoid unnecessary use of restrictive measures. Over time, the tool has become increasingly structured in an attempt to remove individual discretion by those administering it. On one view, this could reduce the risk of arbitrary decisions influenced by the views of individual officers. However, the outputs from the tool (the security assessments) are only as good as the data that are entered into it. The predominant data are numerical counts of incidents of a particular type as reported by Serco. If the data is not of high quality then the security assessments will not be accurate. Several of the case studies raise questions about the quality of the inputs.
- (c) I am concerned about the way in which incidents are categorised for the purposes of the SRAT. For example, a commonly used category is 'abusive/aggressive behaviour' which encompasses both the use of bad language and conduct that is physically aggressive (but that does not amount to an assault). A count of incidents of this type is used as a data point when calculating a risk rating for 'aggression/violence' where the underlying conduct (eg bad language) may not have any element of physical aggression or violence to it and may be an understandable product of long term immigration detention.

#### Use of restraints

- (a) Unlike equivalent guidelines in the UK, Australian guidelines about the use of restraints in immigration detention lack clarity about how to deal with situations where health professionals recommend that restraints not be applied.
- (b) Similarly, there appears to be a lack of clarity about the role of IHMS when assessing whether or not restraints should be applied. Despite a contractual requirement to consult IHMS prior to any planned use of force, there do not appear to be any clear guidelines about how referrals to IHMS are to occur or about what to do once the advice is received. Further, there does not appear to be any system of record keeping relating to advice provided by IHMS. On more than one occasion, medical notes record the views of IHMS officers that they have no control or influence over the question of whether restraints are to be applied.

- (c) In some operations involving the planned application of restraints to a number of different people, there has been a lack of focus on whether restraints should be applied to particular individuals within that group. This is apparent in the case study involving Mr CE but is most clear in the Wickham Point extraction. It is not sufficient in such cases for a blanket approval to be given for restraints to be applied to any person. The circumstances of individuals to be restrained still need to be taken into account individually.
- (d) I am concerned about examples of restraints being applied to people with low security risk ratings, to a man diagnosed with mental illness who had no history of aggressive or violent behaviour, to a 17 year old boy, and to two men in wheelchairs.
- (e) I am concerned that the department has apparently authorised the use of spit hoods on detainees in circumstances where Serco officers are not provided with any training in their use, including in assessing whether or not the use of a spit hood is appropriate.

#### Record keeping

- (a) There are several examples of poor record keeping. In particular, there does not appear to be a clear protocol about recording instructions from the captain of an aircraft about the use of restraints during flight. On more than one occasion, such records were not available.
- (b) Some of the specific complaints show a laxity in either seeking or granting approval for the use of restraints. For example, in two cases Mr DB was restrained on escort prior to approval for the use of restraints being received.
- (c) Detainees who refuse to be handcuffed to attend medical appointments outside of the detention facility have been asked to sign forms that say that they have 'refused treatment'. Several detainees have refused to sign such forms on the basis that they want treatment but refuse to be handcuffed in order to receive it.
- (d) On more than one occasion involving planned use of force, handheld cameras used to record the incident were turned on after the use of force had already commenced.

## 2 Recommendations

14. As a result of this inquiry, I make the following recommendations. More detail on the findings and recommendations of this inquiry is set out in section 12 below.

### **Recommendation 1**

In order to remedy or reduce the loss or damage suffered by the six individual complainants and three family groups who I have found suffered detriment as a result of identified breaches of their human rights, the Commission recommends that:



- (a) The Commonwealth pay to Mr AY, Mr CE, Mr DB, Mr EJ, Mr FE, Mr KE and his family, Ms LC and her family and Mrs MD and her family an appropriate amount of compensation to reflect the loss and damage they have suffered as a result of the breaches of their human rights identified in the course of this inquiry.
- (b) The Commonwealth provide a formal apology to Mr KE and his family and to Ms LC and her daughter for the breaches of their human rights identified in the course of this inquiry.

### **Recommendation 2**

The Commission recommends that restraints only be applied to a detainee where an individual assessment of their risk shows that this is warranted.

### **Recommendation 3**

The Commission recommends that the department instruct Serco to cease the practice of restraining all physically fit detainees for the first 28 days of their detention where Serco has not conducted an individual assessment of the detainee's risk that shows that the use of restraints is warranted.

### **Recommendation 4**

The Commission recommends that an independent investigation be undertaken into the circumstances leading to escapes from immigration detention and how these can best be prevented or reduced.

### **Recommendation 5**

The Commission recommends that in the department's joint review of the Security Risk Assessment Tool (SRAT) with Serco, and in the independent review of the SRAT being conducted by an external consultant, the following issues be considered:

- (a) separating incidents of 'abusive' behaviour from incidents of 'aggressive' behaviour
- (b) removing incidents of 'abusive' behaviour from inclusion in the SRAT altogether
- (c) incorporating a review process for assessing whether incidents are sufficiently material for inclusion on a person's risk assessment, and for removing incidents from a person's risk assessment that are not sufficiently material
- (d) incorporating a process for removing older incidents from a person's risk assessment.

### **Recommendation 6**

The Commission recommends that a copy of this report be provided to the external consultant engaged by the department to conduct an independent review of the SRAT, so that the human rights concerns identified in this report can be taken into account in that review.

### **Recommendation 7**

The Commission recommends that the department publish the results of the joint review of the SRAT it is undertaking with Serco and the report of the independent review of the SRAT being undertaken by an external consultant.

### **Recommendation 8**

The Commission recommends that, following the publication of the reviews of the SRAT, the department conduct a public inquiry in relation to risk assessment and the use of force in immigration detention.

### **Recommendation 9**

The Commission recommends that the department develop a review process to ensure that:

- (a) all instructions relating to the use of force in immigration detention are regularly evaluated for compliance with international human rights standards, and
- (b) these instructions are being complied with.

### **Recommendation 10**

The Commission recommends that:

- (a) any pre-planned use of force be video recorded from the start of the operation until its conclusion
- (b) the video recording be carried out by a person trained to do so
- (c) the recording be clear, include sound, and capture the entirety of the operation
- (d) the requirement for recording and for the training of staff in recording be included in procedures manuals dealing with the use of force
- (e) there be protocols for the storage and retention of video recordings so that they are available for any review of use of force incidents.

### **Recommendation 11**

The Commission recommends that where detention centre staff such as Emergency Response Team officers are wearing body cameras:

- (a) the cameras are turned on throughout use of force incidents
- (b) they film continuously
- (c) the sound accompanying the video is turned on during the incident
- (d) these requirements are included in procedures manuals dealing with the use of force.

### **Recommendation 12**

The Commission recommends that the department's Detention Services Manual and the manuals for private detention service providers engaged by the department make clear that:

- (a) there is a presumption against the use of restraints, including handcuffs, during transfers between detention centres and during escorts to appointments
- (b) the use of restraints, including handcuffs, should be a measure of last resort
- (c) prior to each occasion when the use of restraints is proposed in relation to a detainee, there should be a new individualised risk assessment for that detainee in the context of the particular operation that takes into account:
  - (i) any general risk assessment prepared by the detention operator based on the relevant incidents that a detainee has been involved in while in immigration detention
  - (ii) the particular requirements of the operation, for example, a transfer between detention centres
  - (iii) whether that operation can be conducted safely without the need for restraints to be applied
- (d) the risk assessment should consider whether restraints should be applied during transit and, if so, at which point in the journey it may be appropriate to remove them
- (e) restraints should not be routinely applied to a particular class of detainees, including detainees generally assessed as being 'high' risk, without an individualised risk assessment of the kind described above being carried out
- (f) restraints should be used only for the shortest period of time necessary in the circumstances
- (g) the necessity for the continued use of restraints should be regularly re-evaluated during the course of an operation.

### **Recommendation 13**

The Commission recommends that, consistently with the practice adopted in the United Kingdom, the department's Detention Services Manual and the manuals for detention service providers engaged by the department make clear that:

- (a) instruments of restraint should not be used on detainees who are under 18 years of age
- (b) there is a presumption against the use of restraints where a detainee's mobility is severely limited, for example when they are on crutches or using a wheelchair.

#### **Recommendation 14**

The Commission recommends that for each pre-planned use of force in the context of an operation involving more than one detainee, there is an individual assessment of the necessity for the use of restraints in relation to each detainee involved in the operation. There should be no presumption that a detainee should be restrained only because it is necessary to restrain another detainee.

#### **Recommendation 15**

Subject to recommendation 16 below, and consistently with the practice adopted in the United Kingdom, the Commission recommends that the department's Detention Services Manual and the manuals for detention service providers engaged by the department make clear that:

- (a) the Detention Service Provider must consult with the Detention Health Services Provider prior to the application of any planned use of force against a detainee
- (b) if the Detention Health Services Provider advises that there are medical reasons for restraints not to be used on a detainee, then restraints should not be used on that detainee
- (c) a healthcare professional may direct the removal of restraints in certain circumstances, for example if:
  - (i) there is an immediate risk to the health of the detainee
  - (ii) the detainee is in pain or discomfort
  - (iii) the restraints are impeding treatment, clinical examination or ongoing clinical monitoring
- (d) a direction from a healthcare professional for restraints to be removed must be considered as a matter of urgency
- (e) if a healthcare professional directs the removal of restraints because of an immediate risk to the health of the detainee, then the restraints must be removed
- (f) if a healthcare professional directs the removal of restraints because they are impeding examination or treatment, the restraints must be removed.

#### **Recommendation 16**

The Commission recommends that the department develop a protocol to be followed when there is a dispute between escort staff and medical practitioners about whether restraints are to be used on a detainee. That protocol may include the sharing of risk assessment information with medical practitioners on an informal basis and paths for the escalation of the dispute to more senior detention services and medical officers.

#### **Recommendation 17**

The Commission recommends that pre-planned use of force, including use of restraints, not commence prior to approval for the use of force being received.

### **Recommendation 18**

The Commission recommends that the department develop a record keeping protocol to record:

- (a) the requests by the detention service provider to medical professionals; and
- (b) the advice received by the detention service provider from medical professionals about whether force or restraints should be used on particular detainees. The Commission does not consider that it is sufficient for the detention service provider to rely on medical notes that merely observe that a client is to be handcuffed without a considered assessment of whether such restraint is appropriate.

### **Recommendation 19**

The Commission recommends that the department develop a record keeping protocol to record instructions from the captain of an aircraft carrying immigration detainees about whether or not the captain requires the detainees to be restrained during the course of the flight.

### **Recommendation 20**

The Commission recommends that if spit hoods are to remain an approved means of restraint, that the department develop policies, procedures, guidelines and training documents about the circumstances in which spit hoods may be used. Such materials should recognise that this is a method of restraint that is degrading and that spit hoods should not be used otherwise than in exceptional circumstances where their use is clearly necessary, for example to protect the safety of others.

### **Recommendation 21**

The Commission recommends that where a person is being transferred between immigration detention facilities, the department and facility staff should ensure as far as possible that the person:

- (a) is given adequate notice of the transfer
- (b) receives a clear explanation of the reasons for the transfer
- (c) is given an opportunity to dress and pack their belongings and notify family members, friends and legal representatives.

### **Recommendation 22**

The Commission recommends that where there is a pre-planned use of force involving more than one detainee:

- (a) the planning documents for the operation consider whether force or restraints are necessary in relation to each detainee
- (b) authorisation is separately obtained for the use of force or restraints in relation to each detainee.

### **Recommendation 23**

The Commission recommends that when transfers involve family units, the department and facility staff should ensure as far as possible that families are not separated during the transfer. If it is necessary for family members to be temporarily separated, they should be promptly informed of the location of the other members of their family and when they will be reunited.

### **Recommendation 24**

The Commission recommends that when planning operations involving the transfer of family groups in immigration detention, more consideration be given to the impact that the nature of the operation is likely to have on vulnerable detainees. In particular, more consideration should be given to whether the display of force involved in the operation is likely to be disturbing for children. In those cases, modifications should be made to the operation to reduce the adverse impacts on them.

## 3 Legal framework for human rights inquiry

### 3.1 Functions of the Commission

15. Section 11(1) of the AHRC Act identifies the functions of the Commission. At the time that the complaints dealt with in this report were made to the Commission, s 11(1)(f) gave the Commission the following functions:
  - to inquire into any act or practice that may be inconsistent with or contrary to any human right, and:
    - (i) where the Commission considers it appropriate to do so—to endeavour, by conciliation, to effect a settlement of the matters that gave rise to the inquiry; and
    - (ii) where the Commission is of the opinion that the act or practice is inconsistent with or contrary to any human right, and the Commission has not considered it appropriate to endeavour to effect a settlement of the matters that gave rise to the inquiry or has endeavoured without success to effect such a settlement—to report to the Minister in relation to the inquiry.
16. Section 20(1)(b) of the AHRC Act requires the Commission to perform the functions referred to in s 11(1)(f) when a complaint in writing is made to the Commission alleging that an act is inconsistent with or contrary to any human right.
17. Section 8(6) of the AHRC Act requires that the functions of the Commission under s 11(1)(f) be performed by the President.
18. The rights and freedoms recognised by the ICCPR and the CRC are ‘human rights’ within the meaning of the AHRC Act.<sup>1</sup>

## 3.2 Scope of 'act' and 'practice'

19. The terms 'act' and 'practice' are defined in s 3(1) of the AHRC Act to include an act done or a practice engaged in by or on behalf of the Commonwealth or an authority of the Commonwealth or under an enactment.
20. Section 3(3) provides that the reference to, or to the doing of, an act includes a reference to a refusal or failure to do an act.
21. The functions of the Commission identified in s 11(1)(f) of the AHRC Act are only engaged where the act complained of is not one required by law to be taken,<sup>2</sup> that is, where the relevant act or practice is within the discretion of the Commonwealth, its officers or agents.

## 3.3 Right of detainees to be treated with humanity and dignity

22. Article 10(1) of the ICCPR provides:

All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.

23. General Comment 21 on article 10(1) of the ICCPR by the United Nations Human Right Committee (UN HR Committee) states:

Article 10, paragraph 1, imposes on State parties a positive obligation towards persons who are particularly vulnerable because of their status as persons deprived of their liberty, and complements for them the ban on torture or other cruel, inhuman or degrading treatment or punishment contained in article 7 of the Covenant. Thus, not only may persons deprived of their liberty not be subjected to treatment which is contrary to article 7 ... but neither may they be subjected to any hardship or constraint other than that resulting from the deprivation of liberty; respect for the dignity of such persons must be guaranteed under the same conditions as that of free persons.<sup>3</sup>

24. The above comment supports the conclusions that:

- article 10(1) imposes a positive obligation on State parties to take actions to prevent inhumane treatment of detained persons
- the threshold for establishing a breach of article 10(1) is lower than the threshold for establishing 'cruel, inhuman or degrading treatment' within the meaning of art 7 of the ICCPR
- the article may be breached if the detainees' rights, protected by one of the other articles in the ICCPR, are breached unless that breach is necessitated by the deprivation of liberty.

25. The above conclusions about the application of article 10(1) are also supported by the jurisprudence of the UN HR Committee<sup>4</sup> which emphasises that there is a difference between the obligation imposed by article 7(1) not to engage in 'inhuman' treatment and the obligation imposed by article 10(1) to treat detainees with humanity and respect for their dignity. In *Christopher Hapimana Ben Mark Taunoa v The Attorney General*,<sup>5</sup> the Supreme Court of New Zealand explained the difference between these two concepts as follows:

A requirement to treat people with humanity and respect for the inherent dignity of the person imposes a requirement of humane treatment ... the words 'with humanity' are I think properly to be contrasted with the concept of 'inhuman treatment' ... The concepts are not the same, although they overlap because inhuman treatment will always be inhumane. Inhuman treatment is however different in quality. It amounts to denial of humanity. That is I think consistent with modern usage which contrasts 'inhuman' with 'inhumane'.<sup>6</sup>

26. The decision considered provisions of the New Zealand Bill of Rights which are worded in identical terms to articles 10(1) and 7(1) of the ICCPR.

27. The content of article 10(1) has been developed with the assistance of a number of United Nations instruments that articulate minimum international standards in relation to people deprived of their liberty, including:

- the *Standard Minimum Rules for the Treatment of Prisoners* (Standard Minimum Rules);<sup>7</sup> and
- the *Body of Principles for the Protection of all Persons under Any Form of Detention* (Body of Principles).<sup>8</sup>

28. The United Nations Human Rights Committee has invited States Parties to indicate in their reports the extent to which they are applying the Standard Minimum Rules and the Body of Principles.<sup>9</sup> At least some of these principles have been determined to be minimum standards regarding the conditions of detention that must be observed regardless of a State Party's level of development.<sup>10</sup>

29. Rule 54(1) of the Standard Minimum Rules provides:

Officers of the institutions shall not, in their relations with the prisoners, use force except in self-defence or in cases of attempted escape, or active or passive physical resistance to an order based on law or regulations. Officers who have recourse to force must use no more than is strictly necessary and must report the incident immediately to the director of the institution.

30. This rule provides limits on the circumstances in which force may be used, and limits the use of force in those circumstances to what is necessary.

31. Standard Minimum Rule 94 requires that civil prisoners 'shall not be subjected to any greater restriction or severity than is necessary to ensure safe custody and good order'.

32. The prohibition in article 7 of the ICCPR is absolute and non-derogable. A person's treatment in detention must not involve torture or cruel, inhuman or degrading treatment or punishment.



33. In the case of *Wilson v Philippines*, the United Nations Human Rights Committee found a breach of article 7 of the ICCPR where a prisoner was treated violently in detention:

The Committee considers that the conditions of detention described, as well as the violent and abusive behaviour both of certain prison guards and of other inmates, as apparently acquiesced in by the prison authorities, are seriously in violation of the author's right, as a prisoner, to be treated with humanity and with respect for his inherent dignity, in violation of article 10, paragraph 1. As at least some of the acts of violence against the author were committed either by the prison guards, upon their instigation or with their acquiescence, there was also a violation of article 7.<sup>11</sup>

34. States have a responsibility to ensure that the rights guaranteed in articles 7 and 10 of the ICCPR are accorded to detainees in privately run detention facilities.<sup>12</sup>
35. In previous inquiries the Commission has found that the use of force by detention service providers on detainees in immigration detention amounted to a breach of their human rights.

#### **AHRC report No. 35**

A detainee was grabbed by the throat by an officer of GSL (Australia) Pty Ltd, the then detention service provider at Villawood Immigration Detention Centre, and had his head forced back against a wall. The officer then used force to subject the detainee to an unauthorised strip search. The Commission found that this conduct was in breach of articles 7 and 10 of the ICCPR.<sup>13</sup>

### 3.4 Rights of children

36. There are equivalent rights accorded to children under the CRC.<sup>14</sup> Children are entitled to special protection given their greater vulnerability to a breach of their rights. Additional care should be taken when considering authorisation for the use of force against children.
37. The wording in article 10(1) of the ICCPR is replicated in article 37(c) of the CRC, which provides that:

Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age.

38. Similarly, the wording in article 7 of the ICCPR is replicated in article 37(a) of the CRC.
39. Further, article 19 of the CRC provides:

States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

40. The *United Nations Rules for the Protection of Juveniles Deprived of their Liberty* (JDL Rules) provide some guidance on the use of force within a detention environment.<sup>15</sup> The use of force on children should only be used in exceptional circumstances, where all other 'control methods' have been exhausted and failed. Use of force should not cause humiliation or degradation and should be used only for the shortest possible period of time. Any use of force should be used only under the order of the director of the facility and be subject to higher review.<sup>16</sup>
41. The United Nations Committee on the Rights of the Child has said that restraint or force can be used on a child only when the child poses an imminent threat of injury to themselves or others, and only when all other means of control have been exhausted.<sup>17</sup>
42. In previous inquiries the Commission has found that the use of force by detention service providers on children in immigration detention amounted to a breach of their human rights.

#### **AHRC report No. 27**

A seven year old boy detained at Woomera Immigration Reception and Processing Centre was struck across the legs with a baton by an officer of Australasian Correctional Management Pty Ltd, the then detention services provider there. This occurred during a riot at the centre and while the boy was being carried by his mother. The Commission found that the act of striking the child with a baton was in breach of articles 37(a) and (c) of the CRC and articles 7 and 10 of the ICCPR.<sup>18</sup>

#### **AHRC report No. 46**

A twelve year old boy detained at Woomera Immigration Reception and Processing Centre sustained a slight lump to the right side of his head and complained of pain to his face and wrists after being forcibly transferred by Australasian Correctional Management officers from Woomera Immigration Detention Centre to Baxter Immigration Detention Centre. The Commission found that the use of force against the child was more than strictly necessary in the circumstances and, accordingly, constituted a breach of article 10(1) of the ICCPR.<sup>19</sup>

## 3.5 European case law on use of restraints

43. A number of judgments of the European Court of Human Rights (ECtHR) and courts in the United Kingdom have considered whether the use of mechanical restraints on prisoners in certain circumstances was contrary to article 3 of the European Convention on Human Rights (ECHR).<sup>20</sup> Article 3 of the ECHR is the equivalent of article 7 of the ICCPR. It prohibits torture or inhuman or degrading treatment or punishment.

44. There is no equivalent to article 10 of the ICCPR in the ECHR. As noted above, conduct may not reach the standard required for a breach of article 7 of the ICCPR but still amount to a failure to treat a person with humanity and with respect for their inherent dignity as a human person, contrary to article 10 of the ICCPR. As a result, the case law described below is useful when considering minimum standards of treatment. However, it should not be seen as an exhaustive statement of what is required of authorities when considering the use of restraints on detainees. The majority of cases relate to prisoners rather than to people in administrative immigration detention, where different considerations are relevant. People who are administratively detained could usually expect conditions involving less restraint and more freedom of movement than people who are detained following a conviction for an offence.
45. In general, it does not amount to degrading treatment to require a prisoner to wear handcuffs during escorts outside prison if restraints are reasonably necessary in the circumstances: for example, if there is a reason to believe that the prisoner will attempt to escape or cause injury or damage.<sup>21</sup> However, this conclusion is based on such a risk assessment being properly made. Further, the general rule is subject to modification where there is a high level of vulnerability by the prisoner.
46. In *Mouisel v France* (2004) 38 EHRR 34, a prisoner had been sentenced to 15 years imprisonment following his conviction for armed robbery, kidnapping and fraud. While in prison he was diagnosed with leukaemia and he required chemotherapy at a local hospital. As a result of his condition, he was weakened and no longer posed any physical danger. Despite this, he was handcuffed while being escorted to and from hospital. There was a factual dispute about whether he remained restrained while receiving chemotherapy. The ECtHR found that there had been a breach of article 3 of the ECHR in relation to the use of handcuffs. It held that:
- In this case, having regard to the applicant's health, to the fact that he was being taken to hospital, to the discomfort of undergoing a chemotherapy session and to his physical weakness, the court considers that the use of handcuffs was disproportionate to the needs of security. As regards the danger presented by the applicant, and notwithstanding his criminal record, the Court notes the absence of any previous conduct or other evidence giving serious grounds to fear that there was a significant danger of absconding or resorting to violence.<sup>22</sup>
47. The ECtHR referred with approval to recommendations of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT).<sup>23</sup> More recently, the CPT has provided guidance on the use of restraints on people detained in immigration detention facilities. The starting point is that the use of restraints needs to be justified in each particular case based on an individualised risk assessment. The CPT said that:
- Applying handcuffs as a matter of routine to immigration detainees whenever they leave their detention facility, such as on hospital transfers, is disproportionate; the use of means of restraint should be considered on individual grounds and based on the principle of proportionality.<sup>24</sup>
48. Other advice by the CPT is considered in more detail in section 9 below when considering the use of face masks or spit hoods during the removal of people from Australia by air.

49. English case law also emphasises the need for individualised risk assessments in making decisions about the placement of prisoners. In *R (Vary & others) v Secretary of State for the Home Department* [2004] EWHC 2251, two prisoners challenged decisions to reclassify them as Category C prisoners (prisoners who cannot be trusted in open conditions but who do not have the resources and will to make a determined escape attempt) rather than Category D prisoners (prisoners who can be reasonably trusted in open conditions). The reclassification took place following a change in policy prompted by the escape of another prisoner. Lord Justice Beatson noted that the Secretary was entitled to introduce a new policy 'provided that the policy did not automatically determine the outcome and [the Secretary] gave individual consideration on proper grounds to the individual cases'.<sup>25</sup> Ultimately, his Lordship set aside decisions to reclassify two prisoners on the basis that there was no indication that relevant personal circumstances of each of them had been taken into account.
50. There is also a need to distinguish between the use of restraints on medical escorts to and from hospital and the use of restraints during medical treatment itself. In *FGP v Serco plc and Secretary of State for the Home Department* [2012] EWHC 1804, the High Court of England and Wales considered the obligations of Serco plc, as the operator of Immigration Removal Centres in the UK, to immigration detainees when they were required to attend hospital. Lord Justice Collins held that there is a presumption that restraints should not be applied during medical treatment and that officers escorting the patient should not be within earshot during the course of the consultation.<sup>26</sup> In order to rebut that presumption, it must be demonstrated that restraints or the presence of an escort during the consultation is necessary. Given this presumption, those responsible for escorting patients to hospital should not approach their task on the basis that restraints and the presence of escorts will continue unless medical staff request otherwise.<sup>27</sup> That is, the onus is not on medical staff to request that restraints be removed for treatment. This issue should be actively considered by those responsible for the escort.

## 4 Legal framework for use of force in immigration detention

51. Since 1992, Australia has operated a system of mandatory immigration detention. The *Migration Act 1958* (Cth) (Migration Act) requires people to be detained if they are non-citizens in Australia without a visa.<sup>28</sup> Section 5 of the Migration Act provides that 'detain' means:
- (a) take into immigration detention; or
  - (b) keep, or cause to be kept, in immigration detention;
- and includes taking such action and using such force as are reasonably necessary to do so.
52. Since November 1997, the provision of detention services has been outsourced by the department to private organisations.<sup>29</sup> At present, the detention service provider is Serco Australia Pty Ltd (Serco).

53. On 10 December 2014, Serco and the Commonwealth entered into an Immigration Detention Facilities and Detainee Services Contract for an initial term of 5 years. Pursuant to this contract, Serco was responsible for providing garrison services, facilities management services, security services, transport and escort services, and welfare and engagement services in relation to immigration detention facilities in Australia. In relation to the obligation to provide security services, the contract provides that:
- (a) The Service Provider [Serco] must support the operation of the Network through the delivery of Security Services at each Facility that:
    - (i) support, maintain and assure the continuity and integrity of internal and external operations of the Facility;
    - (ii) enable the Service Provider to manage routine events in the Facility;
    - (iii) enable the Service Provider to respond promptly and flexibly to any non-routine event or Incident;
    - (iv) scale to accommodate the unique needs, risks and challenges associated with each Detainee, and the Detainee cohort as a whole; and
    - (v) is informed by intelligence required under clause 1.11 (Security Intelligence Obligation) of this Section 4 (Security Services).<sup>30</sup>
54. In relation to the use of force, the contract provides that:
- (a) The Service provider must:
    - (i) ensure that force is not used unless as a measure of last resort when all other methods have failed or have been assessed as inadequate, and then only with the reasonable level of force necessary to resolve the situation in accordance with directions given by the Department;
    - (ii) ensure that, whenever force is used on Detainees that are frail, elderly or Minors, Service Provider Personnel take all reasonable precautionary measures to ensure the safety of the Detainee that are appropriate to the circumstances of that Detainee;
    - (iii) ensure that Service Provider Personnel who use force are trained and accredited in the use of force in accordance with applicable law;
    - (iv) monitor and control the use of force in each Facility; and
    - (v) ensure that Service Provider Personnel apply the use of force in accordance with applicable law.
  - (b) When the use of force is planned by the Service provider, the Service Provider must:
    - (i) consult with the Detention Health Services Provider prior to using any planned use of force against a Detainee to ensure that no medical reasons preclude the use of force against the relevant Detainee; and
    - (ii) seek the Department's approval for that planned use of force, prior to such force being used against a Detainee.<sup>31</sup>

55. When Serco has used force or instruments of restraint such as handcuffs on a detainee, it must prepare an incident report for the department and refer the detainees to the Detention Health Services Provider for a medical examination immediately after the use of force or restraints.<sup>32</sup>
56. As described in the department's Detention Services Manual, both the department and 'facilities detention service providers (FDSPs)' such as Serco owe a duty of care to all persons in all types of held immigration detention. This means that they are legally obliged to exercise reasonable care to prevent detainees from suffering reasonably foreseeable harm.<sup>33</sup> The department's duty of care is non-delegable, which means that it cannot be delegated or transferred to anyone else.<sup>34</sup>
57. When the department contracts out the provision of services to people in held detention to third parties, the department has a responsibility to ensure the contracted service providers are qualified and can meet the standards outlined in the contract. While these third parties must also discharge their own duty of care obligations to a detainee in held detention, this duty is additional to, and does not substitute, the department's duty of care responsibilities.<sup>35</sup>
58. In addition to the department's duty of care, the department recognises that international human rights standards can inform the standard of care a detainee is to receive while detained in an immigration detention facility.<sup>36</sup> As noted above, these international standards require that detainees are treated fairly and reasonably within the law and that conditions of immigration detention ensure the inherent dignity of the human person.
59. In September 2015, the department's Detention Services Manual provided that the application of these obligations to the use of force in immigration detention means that:
- conflict resolution through negotiation and de-escalation is, where practicable, to be considered before the use of force and/or restraint is used
  - reasonable force and/or restraint should only be used as a measure of last resort
  - reasonable force and/or restraint may be used to prevent the detainee inflicting self-injury, injury to others, escaping or destruction of property
  - reasonable force and/or restraint may only be used for the shortest amount of time possible to the extent that is both lawfully and reasonably necessary. If the management of a detainee can be achieved by other means, force must not be used
  - the use of force and/or restraint must not include cruel, inhumane or degrading treatments
  - the use of force and/or restraint must not be used for the purposes of punishment
  - the excessive use of force and/or restraint is unlawful and must not occur in any circumstances
  - the use of excessive force on a detainee may constitute an assault

- all instances where use of force and/or restraint are applied (including any follow-up action), must be reported in accordance with the relevant FDSP operational procedures.<sup>37</sup>

60. According to the Detention Services Manual, the use of force is considered to be reasonable if it is objectively justifiable and proportionate to the risk faced.<sup>38</sup>
61. The department says that its 'use of force' policy and instructions were comprehensively reviewed in 2016 and again in early 2017 while the Commission's inquiry was in progress. The Commission asked the department for a copy of these revised policies but they were not provided. The Commission's recommendations have therefore taken the department's policies as at 2015 as its starting point.
62. Serco is a Registered Training Organisation and delivers the 'Certificate IV – Security Operations' course as part of the induction training course for 'detainee-facing personnel' working for Serco. All Serco officers are required to have successfully completed this course before being permitted to apply restraints to detainees. Australian Border Force staff are required to successfully complete a 5 week 'Operational Safety Training' package before they are authorised to use force, including restraints, on detainees.

## 5 Use of handcuffs

63. Throughout 2017, the Commission conducted inspections of each of the immigration detention centres in the Australian network, including Christmas Island. At the time of this report, it has published reports of detention inspections of Maribyrnong Immigration Detention Centre, Melbourne Immigration Transit Accommodation, Villawood Immigration Detention Centre, Yongah Hill Immigration Detention Centre, Perth Immigration Detention Centre, Adelaide Immigration Detention Centre, Brisbane Immigration Transit Accommodation and Christmas Island Immigration Detention Centre.<sup>39</sup> One of the key themes of these inspections was the use of mechanical restraints – handcuffs – during escorts of certain detainees outside detention centres. Handcuffs were used in transfers between detention centres and also when detainees were escorted to court or to medical appointments. The use of restraints was one of the most commonly-raised concerns by detainees in their interviews with Commission staff.
64. In 2018, the Commission conducted inspections of Villawood Immigration Detention Centre, Brisbane Immigration Transit Accommodation, Melbourne Immigration Transit Accommodation, Yongah Hill Immigration Detention Centre and several 'alternative places of detention'. The focus of the Commission's 2018 inspections was on risk management in immigration detention. By 2018, the Commission observed that the use of restraints was widespread and routine during transfers between immigration detention centres and during escorts to medical and court appointments.

## 5.1 Australian requirements

65. The department's Detention Services Manual provides that mechanical restraints such as handcuffs may be approved by the Secretary of the department for use in immigration detention facilities.<sup>40</sup> In relation to travel to and from detention, the Manual says:

Restraint during escorted visits and scheduled travels only applies to detainees who have a serious or violent criminal history, those who have a history of escape, and those for whom the risk assessment indicates that they potentially pose a high risk. In practice this means that reasonable force and/or restraint will be determined following risk-management procedures.<sup>41</sup>

66. Instruments of restraint must:

- never be applied as a punishment or for discipline
- never be applied as a substitute for medical treatment
- never be used for convenience or as an alternative to reasonable staffing
- be removed once the threat has diminished and the officer believes that the detainee is no longer a threat to themselves, others or property.<sup>42</sup>

67. Serco's contract with the Commonwealth provides that Serco must 'ensure that restraints are not used in a manner which is likely to cause injury, serious discomfort or potential danger to a Detainee'.<sup>43</sup>

68. Serco's Operational Safety Manual provides that the application of restraints while travelling on a commercial aircraft with a detainee 'will only be undertaken on the authority of the aircraft captain/commander'.<sup>44</sup>

69. Training for Serco officers on the use of restraints has been developed from a system known as Law Enforcement Defensive Tactics 'Control and Restraint' Techniques. The department says that this system has been adopted by a range of law enforcement agencies and correctional institutions internationally and is focused on ensuring that restraints are used correctly, are appropriate to the situation and minimise the potential for injury.

## 5.2 UK requirements

70. It is instructive to compare these requirements with the UK position in relation to the use of restraints. In August 2016, the UK Home Office issued a Detention Services Order governing the use of restraints for escorted movements of immigration detainees.<sup>45</sup> Relevantly, the Detention Services Order provided that, in the UK:

- there is a presumption against the use of restraint equipment during visits outside immigration detention facilities and during escort journeys
- any use of restraint must be subject to an individual risk assessment which must be undertaken for each individual escorted move, even if it is a regular appointment



- the risk assessment must consider whether handcuffs should be applied during transit and, if so, at which point in the journey or prior to consultation it may be appropriate to remove them
- restraint equipment must not be used in the cubicle of a cellular vehicle
- authority for the use of restraints must be given by the Duty Manager before any use of restraint equipment
- restraint equipment must not be used on a detainee who is under 18 years old
- restraints will not normally be necessary when the detainee's mobility is severely limited eg when he or she is on crutches
- use of restraints should only ever be used on a pregnant detainee to prevent her from harming herself or someone else and pregnant detainees should not be placed in a waist restraint belt or leg restraints.

71. The Detention Services Order provides significant detail about the role of healthcare professionals in decision making about the use of restraints. In particular, the order provides that:

- a healthcare professional may direct the removal of restraints in certain circumstances, for example if:
  - there is an immediate risk to the health of the detainee
  - the detainee is in pain or discomfort
  - the restraints are impeding treatment, clinical examination or ongoing clinical monitoring.
- a direction from a healthcare professional for restraints to be removed must be considered as a matter of urgency
- if a healthcare professional directs the removal of restraints because of an immediate risk to the health of the detainee, the restraints must be removed
- if a healthcare professional directs the removal of restraints because they are impeding examination or treatment, the restraints must be removed.

72. The Detention Services Order sets out a protocol to be followed where escort staff have concerns about the removal of restraints to facilitate examination or treatment. Where the risk of escape remains high, or if escort staff are in any doubt about the direction to remove the restraints, the escort staff may share the risk assessment with the healthcare professional where appropriate and must seek to resolve the matter informally. For example, in the case of a risk of absconding, they may request that the examination be conducted in a private room where risk is significantly reduced. Where the direction cannot be resolved informally, the escort staff must inform hospital staff that the restraints will remain in place until a further decision is made by the Duty Manager. The decision of the Duty Manager must be based on the information provided in the individual's risk assessment, any changes in circumstances since the initial risk assessment, and the advice of the healthcare professional. The Duty Manager must speak personally with the healthcare professional if possible. In exceptional circumstances, when the Duty Manager does not approve the removal of handcuffs, the Duty Manager must notify relevant managers within the Home Office.
73. Once a detainee has completed their consultation or treatment and is to be returned to detention, fresh consideration should be given to whether it is appropriate for restraints to be reapplied for the return journey. This decision should take into account any changes in the detainee's clinical condition and any other relevant circumstances. Consultation with the lead healthcare professional on the detainee's health may help when considering whether the original risk factors justifying the use of restraints still apply.
74. It appears that reports of incidents of the use of force are reviewed by a Home Office Immigration Enforcement use of force monitor.

## 6 Security risk assessments

75. Decisions about the use of force in immigration detention, and particularly decisions about when it is appropriate to use mechanical restraints, are dependent on risk assessments conducted by Serco. The Commission has identified a number of concerns with the risk assessment process conducted by Serco. Some of these concerns relate to guidelines provided by the department which deem certain classes of people to be high risk, regardless of their individual circumstances. Other concerns relate to whether the risk assessment tool is sufficiently nuanced to avoid unnecessary use of restrictive measures. Some of these concerns arise from: the increasingly structured nature of the risk assessment tool which aims to remove individual discretion by those administering it; the way in which incidents are categorised for the purposes of this tool; and the potential for inaccurate outcomes if the data entered into the tool is not of high quality.

76. For each 'escort task' carried out by Serco, it must prepare an Escort Operational Order that includes details of the escort.<sup>46</sup> The Escort Operational Order must be approved by the department in certain circumstances, including where the escort task is identified as high or extreme risk.<sup>47</sup> For high and extreme risk escort tasks, Serco may seek approval for the use of restraints or other risk controls.<sup>48</sup> Serco must not use restraints (other than seatbelts) on detainees during an escort task, unless:
- the detainee is attempting to escape
  - the detainee is at risk of causing injury to themselves or others
  - the detainee is damaging property
  - the department has otherwise approved the use of restraints as part of an escort security risk assessment process.<sup>49</sup>
77. In January 2011, an internal review by PricewaterhouseCoopers found that Security Risk Assessments for people in immigration detention were undertaken during reception, but were not routinely recorded in the Detention Services Portal and that 'the quality of some Security Risk Assessments for People in Detention were such that it was difficult to assess these as compliant with Risk Management Strategies'.<sup>50</sup> A subsequent review into major public order incidents at Christmas Island and Villawood IDCs in March and April 2011 recommended that Serco's commitments under the contract with the department in relation to Security Risk Assessments be met fully as a matter of priority.<sup>51</sup> These recommendations were accepted by the department and Serco developed a 'computerised tool'.<sup>52</sup>
78. In April 2012, the department approved the first version of a Security Risk Assessment Tool (SRAT) that had been developed by Serco.
79. On 23 April 2012, the department engaged a consultant to conduct an independent audit of Serco's records relating to Security Risk Assessments. The audit was completed in May 2012. According to submissions from the department, the main finding of the audit relating to Security Risk Assessments for people in detention was that SRAs and accompanying portal records did not provide a sufficient evidence base. The department declined to voluntarily provide the Commission with a copy of this audit when requested.
80. By the end of July 2012, the SRAT had been implemented across all IDCs and work was progressing to complete the implementation at the remaining immigration detention facilities by the end of September 2012.<sup>53</sup>
81. In 2013, following operational reviews of a number of escapes from immigration detention, Serco made some recommendations to the department aimed at 'broadening ... the risk criteria to identify detainees that statistically have a higher likelihood of escape'. The department declined to voluntarily provide the Commission with details of the recommendations made by Serco, citing concerns about criteria used for risk assessment becoming known by detainees. The department said that if a detainee knew the criteria used for security assessment 'they may, for example, seek to mask any adverse traits they have to ensure they receive a favourable assessment'.

82. Since 2013, there has been a change in the cohort of people in immigration detention. At the end of 2013, 95% of people in immigration detention were people seeking asylum who had arrived in Australia by boat.<sup>54</sup> By May 2015, the total number of people in immigration detention had significantly decreased and the proportion of asylum seekers who had arrived by boat in this population had also decreased to around 55%. The other major groups of people in immigration detention were people who had overstayed their visa (23%) and people who had had their visa cancelled, including on character grounds (19%);<sup>55</sup> and these populations were increasing, both as a proportion of the total and in absolute numbers.
83. In May 2015, in response to the recommendations made by Serco, the department provided additional guidance to Serco about cohorts of detainees who should be categorised as being 'high risk'. If a detainee is categorised as 'high risk' then one result is that they must be restrained during escorts outside of the detention centre. Again, the department declined to voluntarily provide the Commission with a copy of the guidance given to Serco, citing the same operational concerns. The department did, however, provide the Commission with a Serco Powerpoint presentation that described one aspect of the guidance.<sup>56</sup> This aspect relates to characteristics of detainees that are known at the time that they enter detention and is not something that can be 'masked'.
84. The guidance provided by the department was that the following cohorts should be considered as 'high risk':
- any single adult male or single adult female
  - who either:
    - had been in detention for less than 30 days; or
    - had a criminal background involving violence or aggression, or any attempted (or actual) abscond/escape, violent or escape oriented history from detention or any form of custody; and
  - had no physical impediments that would impair their ability to overpower or abscond from escort staff.
85. One key change as a result of this guidance was that restraints would now be applied to all physically fit single adult detainees during all escorts in the first 30 days of their detention. The justification given by Serco for this change was that a significant number of escapes from detention occur during the first 30 days that people are detained, predominantly by people categorised as low risk.
86. According to the Serco Powerpoint presentation provided by the department to the Commission, in the period from 1 January 2010 to 30 August 2015, there were 249 escapes from immigration detention. 75 of those escapes (30%) were from people who had been in detention for 30 days or less. Of that group, 53 escapes (71%) were by people who were categorised as 'low risk'; 13 escapes (17%) were by people who were categorised as 'medium risk'; and 9 escapes (12%) were by people who were categorised as 'high risk'.

87. It appears that, generally, the risk of escape decreases the longer a person is in detention. On one view, it may take some time for Serco to make a proper assessment about the risk that a person poses based on their behaviour while in detention. It appears that this view has driven the decision to classify all physically fit single adult detainees as high risk for 30 days, regardless of their personal circumstances.
88. However, a closer look at the statistics provided to the Commission by the department indicates that a similar proportion of escapes (around 31%) occurs among people who have been in detention for more than 7 months. (This is the bulk of detainees: in May 2015, when the instruction from the department was given, around 58% of detainees had been in immigration detention for more than 6 months, and the average time in detention was 13 months).<sup>57</sup> Of this latter group of escapees, 40% of them (31 out of 77) were classified as low risk and a further 22% (17 out of 77) were classified as medium risk. This means that even after detainees have been in detention for more than 7 months, presumably more than a sufficient time to assess risk, almost two thirds of escapes are still by people categorised as low or medium risk.
89. The data suggests that the high rate of escapes in the first 30 days of detention cannot be put down to a temporary lack of information about the risk posed by detainees that is later corrected by experience. It suggests that a more thorough review of the circumstances of particular escapes is required in order to determine why these escapes occurred. It may well be that other changes to Serco's practices could be put in place which are more effective in preventing escapes without the need for low risk detainees to be handcuffed.
90. Further, the changing cohort of people in immigration detention now means that Serco will have more information about potential detainees at the start of their detention. An increasing number of detainees are people who have had their visas cancelled as a result of a criminal conviction and are being transferred from prison to immigration detention. These people will already have had their risk assessed during a period of incarceration.
91. In light of the above, there is less justification for treating all physically fit single adult detainees as high risk for 30 days regardless of their personal circumstances. Almost certainly, such a policy will mean that people who do not present any serious objective risk of escape will be subjected to the highly restrictive practice of use of mechanical restraints. For example, such a blunt policy will mean that backpackers who have overstayed their visas and are detained pending removal will be subject to mandatory handcuffing.
92. There are real questions about whether such an approach can be justified on the numbers. There were 66 escapes by low and medium risk detainees in their first 30 days of detention over a period of 5 years and 8 months from 1 January 2010 to 30 August 2015. During this same period of time, more than 45,000 people arrived in Australia by boat and were detained for some period of time in an Australian immigration detention facility.<sup>58</sup> The incidence of escapes by low and medium risk detainees in their first 30 days of detention, as a proportion of the total number of people detained, was less than 0.15% (one in every 680 detainees). However, this fact has been used to justify the use of handcuffs on 100% of physically fit single adult detainees during their first 30 days of detention.

93. The Serco Powerpoint presentation goes on to identify a key problem inherent in this new requirement. Under a heading of 'possible locally raised issues' the first point is: 'Scrutiny over arbitrary risk assessments for detainees less than 30 days in detention'.<sup>59</sup> In this context, it appears that Serco's description of risk assessments as 'arbitrary' relates to the deeming of certain detainees to be 'high' risk when on an objective analysis a large proportion of them would not be 'high' risk. There is some force in this description. The label is not a description of the actual risk that a detainee presents. Instead, it is applied to all detainees in a very broad class without an assessment of their individual circumstances. I am concerned that this process will result in an inappropriate use of mechanical restraints on many people in immigration detention who ought to be categorised as low risk.
94. In response to my preliminary view, the department said that the policy requirement described above now applies in the first 28 days of a person's stay in detention and 'does not apply where there is sufficient knowledge/information of the detainee to inform the risk assessment'. This is an improvement over a blanket rule for all detainees regardless of their personal circumstances, but it is not clear how this initial risk assessment is conducted and what information is considered to be 'sufficient' in order to avoid a potentially arbitrary use of handcuffs. It appears that this policy is still likely to result in the use of restraints on people who ought to be categorised as low risk, for example if it is their first time in any form of detention.
95. I am also concerned about the way in which security assessments are calculated through the application of the Security Risk Assessment Tool as amended in 2015. In response to a request by the Commission for documents, the department said that it would not voluntarily provide a copy of the SRAT itself to the Commission because it was concerned about compromising security if detainees were aware of how their risk assessments were calculated. Instead, as noted above, the department provided the Commission with a copy of a Serco Powerpoint presentation describing the key changes in general terms. The department has also provided the Commission with a number of completed security assessments in a form that has also been provided to some detainees. The description that follows is drawn from these sources.
96. The SRAT is described by the department as a tool that uses 'a series of mathematical calculations based on known, factual information' to arrive at a number of different risk ratings. The key factual information entered into the tool comprises a numerical count of incidents of a particular type that a detainee has been involved in. There are two columns with sums of incidents: a 'totals' column comprising the number of incidents of a particular type since the person was first detained, and a column with the number of incidents in the last three months.
97. There are 32 different incident types. When a detainee is involved in an incident in detention, Serco will prepare a report and allocate it to a particular incident type. The usefulness of the security assessment depends on this categorisation being done in an accurate way. Some common incident types include:
- abusive/aggressive behaviour
  - assault (various types)
  - contraband found
  - damage (minor or serious)
  - demonstration onsite

- disturbance (minor or major)
- escape (with separate incidents relating to attempts and having tools in possession)
- food/fluid refusal
- self-harm (actual or threatened)
- use of force (when planned or unplanned force is used against a detainee by Serco).

98. The number of incidents in each category (as a total count, and over the last 3 months) is then used to calculate a score for seven 'behavioural risk indicators'. Those risk indicators and the incidents that are relevant for each of them are as follows:

Behavioural risk indicator	Incident type
Aggression	Abusive/aggressive behaviour, use of force
Demonstration	Demonstration onsite, food/fluid refusal
Disorder	Damage (major or minor), riot, disturbance (major or minor)
Escape	Escape (including attempted and mass breakout)
Violence	Any assault category
Contraband	Contraband (found or brought in by visitor), weapon
Self-harm	Self-harm (threatened, actual and attempted serious)

99. There is a separate risk indicator for 'voluntary starvation'. It appears that this may be based on incidents of 'food and fluid refusal' and that the reference to this incident type next to the risk indicator for 'demonstration' may be a mistake. There is also a separate risk indicator for 'criminal history' which is presumably based on other intelligence data.
100. Behavioural risk indicators were previously expressed as a number, but now appear to be colour coded white (where there is no relevant data), yellow, orange or red in increasing order of seriousness.
101. A 'risk assessment raw value' is then calculated based on category scores for the 'behavioural risk indicators' and a weighting assigned to each of the indicators. The department has not provided the Commission with details of the weightings that are applied. In response to my preliminary view, the department noted that some incident categories, such as self-harm, contraband and demonstration, have an increased weighting for incidents that occurred in the previous three months.

102. The final output comprises seven different risk ratings. Five of these describe the person's risk rating for demonstration, escape, self harm, aggression/violence and criminal profile. The two primary risk ratings are for 'DSP Placement Risk' and 'DSP Escort Risk' where DSP appears to stand for Detention Service Provider. These risks are used by Serco to determine where to accommodate detainees within a detention facility and how detainees are to be treated on escort, including whether restraints are to be used.
103. The second version of SRAT sought to provide an enhanced assessment of risk profile by including data about pathway information (ie immigration status and whether the person was on a 'removal pathway'), detainee history (including criminal history), certain kinds of 'escape indicators' and information from security intelligence reports.
104. The department says that the assessed risk rating can be overridden at any time by the relevant Detention Superintendent for transport and escort activities. On 30 April 2018, the department issued a direction to Detention Superintendents reminding them to keep a comprehensive decision record when they make a decision to manually override a security risk rating developed by the SRAT.
105. As noted above, the quality of the ultimate risk rating calculated by the tool is reliant on the quality of information entered into it. For example, some incident types may capture a broad range of conduct of different degrees of seriousness, but are treated in the same way for the purpose of the tool. I am concerned that a commonly used category is 'abusive/aggressive behaviour', which encompasses both the use of bad language and conduct that is physically aggressive (but that does not amount to an assault). A count of incidents of this type is used as a data point when calculating a risk rating for 'aggression/violence' where the underlying conduct (eg bad language) may not have any element of physical aggression or violence to it and may perhaps be a product of long term immigration detention.
106. Mechanical use of the tool without applying common sense can also lead to perverse results. For example, in another inquiry conducted by the Commission, a detainee sought unsuccessfully to be permitted to participate in excursions outside of the detention centre. When these requests were refused, he engaged in what was described as a 'peaceful sit down protest' on a number of occasions. On the basis of information provided to the Commission, it appeared that this was sufficient for him to receive a 'high' risk on his behavioural risk indicator for 'demonstration' and was a substantial factor in his then receiving a 'high' escort risk, disqualifying him from participating in excursions. This circular reasoning – that a person be disqualified from excursions as a result of protesting peacefully about being disqualified from excursions – is one example of the poor outcomes that can result from a mechanical application of a tool without sufficient regard to the quality of the data being put in. This complaint was ultimately able to be resolved following discussions between the Commission and the department.
107. In some of the case studies that follow, I consider not only the risk rating that a detainee has been given, but also the key incidents that led to the allocation of that risk rating, in assessing whether the treatment that the detainee received was appropriate.
108. In July 2018, in response to my preliminary view, the department said that it was undertaking a joint review of the SRAT in conjunction with Serco. It said that this review would take into consideration recommendations made by external scrutiny bodies including the Commission. Section 12.2 below contains recommendations from the Commission about security risk assessments.



109. In October 2018, in response to the Commission's inspection report of the Christmas Island Immigration Detention Centre,<sup>60</sup> the department said that, in recognition of the changing profile of the immigration detention cohort, it had commissioned an independent review of the SRAT to be conducted by an external consultant. It said that this review was expected to commence in late 2018.<sup>61</sup> The Commission considers it important for the consultant engaged to carry out the independent review of the SRAT to be provided with a copy of the Commission's report in the present inquiry so that the consultant can take into account the human rights concerns identified in this report.

## 7 Use of handcuffs in transfers between immigration detention facilities

110. The following three case studies evaluate complaints that have been made to the Commission by three people about the use of handcuffs while they were being transferred between immigration detention facilities. Subsequent sections will consider the use of restraints in the context of other escorts such as to court or to medical appointments, and in removals from Australia.
111. The three case studies in this section deal with a number of significant issues including the importance of obtaining medical advice about the use of handcuffs and the importance of ensuring that the use of handcuffs is justified as necessary for each person who is restrained. The case studies also illustrate a number of important practical issues relating to the use of force, including the need for: adequate video recording; periodic reassessment about the necessity for the use of restraints (particularly for long transfers); and adequate documentation of decisions to use restraints and advice provided by medical professionals and the captains of aircraft used to transport restrained detainees.
112. In summary:
- (a) Mr AY was required to wear handcuffs over a significant wrist wound for 8 and a half hours during a transfer between immigration detention facilities in Sydney and Perth. There are no records requesting approval for the use of handcuffs which explain why it was considered necessary to handcuff him and no records containing an approval for the use of handcuffs. There are no records that suggest that medical practitioners were asked for, or gave, any advice about whether Mr AY should be handcuffed for transport. There are no records that suggest that restraints were required by the captain of the flight. Two days after the transfer, Mr AY's skin was inflamed up to 20cm from his wrist and he was reporting significant pain. I find that the use of handcuffs in these circumstances contributed to Mr AY's pain and discomfort and was contrary to his rights to be treated with humanity and with respect for his inherent dignity.

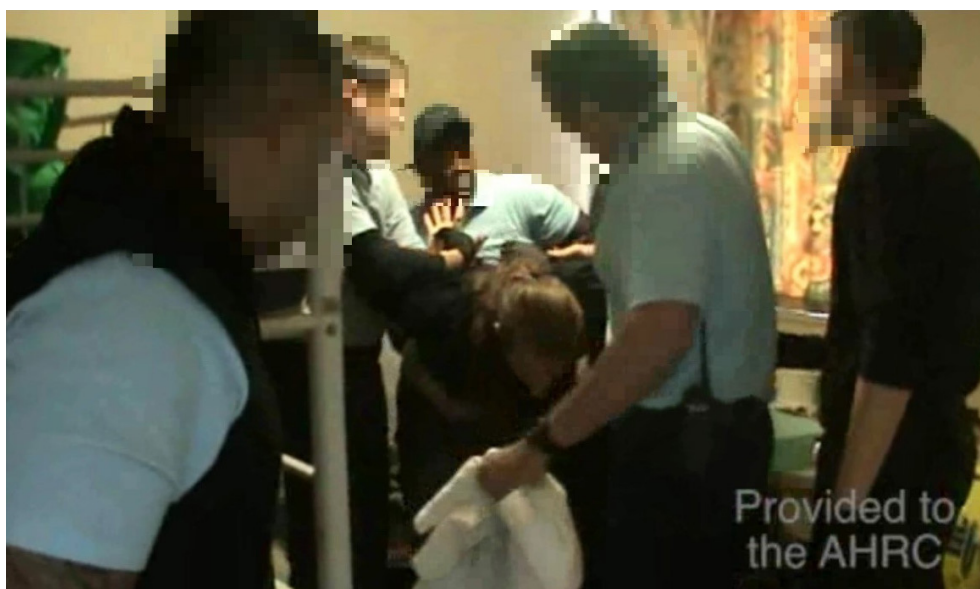
- (b) Mr BC was handcuffed after he physically resisted officers prior to boarding a plane from Darwin to Nauru along with his two sons. The captain of the flight asked that he be restrained and he was handcuffed for the duration of the flight. A log of the flight shows that the handcuffs were checked every 15 minutes. On the basis of the material provided to me, I am not satisfied that the level of force used was inappropriate in the circumstances.
- (c) Mr CE was required to wear handcuffs for more than 12 hours during flights between Christmas Island and Melbourne via Perth. His individual security assessment did not justify the application of restraints. The department has suggested that he was restrained, not because of the risk that he presented individually, but because he was being transferred with other detainees who required restraints. I am not satisfied that the use of restraints on Mr CE was necessary and I find that the application of handcuffs for more than 12 hours was contrary to his rights to be treated with humanity and with respect for his inherent dignity.

## 7.1 Case study: Mr AY

- 113. Mr AY complains that he was required to wear handcuffs over a self-inflicted wrist wound described by doctors as 3cm long and 'quite deep down to the fascia' for a period of 8 and a half hours during a transfer between detention centres. I consider that this was contrary to Serco's contractual requirement not to apply restraints in a manner likely to cause injury or serious discomfort to a detainee. I find that it was also contrary to Mr AY's rights to be treated with humanity and with respect for his inherent dignity.
- 114. Mr AY arrived in Australia from Iran in January 2010 when he was 27 years old and was detained at Villawood Immigration Detention Centre (VIDC) in Sydney from April 2010. While detained at VIDC, he became engaged to an Australian woman living in Sydney who visited him daily in detention. In April 2014, after four years of detention at VIDC, he was told that he was going to be transferred to Curtin Immigration Detention Centre in the remote northwest corner of Western Australia, near the town of Derby. He says that he was not told the reason why he was being transferred.
- 115. In response to questions from the Commission, the department said that Mr AY was transferred from VIDC to Curtin 'due to planned infrastructure works' at VIDC. The department said that these works reduced the capacity of VIDC and that at the time of the works approximately 150 detainees were relocated within the network to allow the redevelopment to proceed. The department said that 'a range of factors such as health, immigration pathway, legal matters [and] immediate family ties were considered prior to transfer'. It is not clear how Mr AY's family ties were taken into account.
- 116. Two days prior to the scheduled date of the transfer, IHMS, the organisation contracted to provide medical services to people in immigration detention, reported that Mr AY was distressed at the prospect of being moved to Curtin and was considering engaging in self-harm. IHMS reported:

Client is perceived to have reached a point where he may potentially engage in self harm as has described his girlfriend as his only hope and is now being moved away from her.

117. Mr AY's fiancée says that one day prior to the transfer she spoke with officers of the department by phone and asked them not to transfer Mr AY because of the impact that their physical separation would have on him.
118. On the day of the transfer, Mr AY resisted being transferred and barricaded himself in his room. Orders were given to use force to extract him from his room. When this took place, Mr AY cut his right wrist.
119. An incident report produced by Serco said:
- The detainee stated that he didn't want to leave VIDC and if [sic] any attempt to extract him will result in him hurting himself. It was not too clear if he stated that he had a sharp instrument to facilitate this threat. ...
- Once all negotiations were exhausted, the orders from ECC was to commence extraction. The three ERT [Emergency Response Team] members entered the room by firstly utilizing the extraction kit to break the door knob for quicker entry, this was successful.
- Upon entry the obstacles that slowed down the extraction by a few vital seconds was the barricade within the room which were the bunks. At this point the detainee did not give any resistance to the officers but stated that he had cut his left [sic: should be right] wrist. The ERT officers placed the detainee in a secure hold maintaining a careful assessment of the cut on his wrist. A towel was placed on the wound to stop the bleeding. The detainee was escorted to the vehicle that was assigned for extraction and was driven to the VIDC property area.
120. Part of the extraction was filmed, starting after the ERT had gained entry to Mr AY's room and after he had already cut himself and finishing when Mr AY was escorted to the vehicle that was assigned for extraction. There is no footage of the start of the incident despite this being a planned use of force. The Commission has viewed this video.



Serco officers grappling with Mr AY.

121. When the camera enters the room, Mr AY is already being held by two male Serco officers, one on each of his arms. A third male Serco officer, who appears to be in charge of the team, says 'cuff him' and pushes Mr AY's head down. The officer then appears to notice that Mr AY's wrist is cut and changes his mind, saying 'Ah, nah, nah, nah. You gonna walk? You gonna walk with me?'. As set out in the Serco incident report, Mr AY was compliant and walked with the officers. The officers do not appear to use more force than is necessary in the circumstances. As they move out of the room the following exchange takes place:

Mr AY: It's just my hand is hurting so bad.  
Officer 2: Let's just get through the door first.  
Mr AY: Just don't put your hand on my wrist.  
Officer 1: Ok. Which one is the cut?



Bleeding from the cut on Mr AY's wrist.

122. As Mr AY is escorted into another building, it is clear from the video that there is a significant amount of blood on his right wrist. One of the officers is holding his arm above the wound. After entering the building, another female Serco officer places a towel over the wound and holds it in place to stop the bleeding. She instructs a fifth officer to 'go in this office or upstairs and get me some gloves, lots of pairs of large gloves please'.



Mr AY is held by two Serco officers while a third officer applies a towel to the bleeding from his wrist.

123. Mr AY is patted down and the first Serco officer, who appears to be in charge, says:

Now, the only sad thing about it, right, I have to cuff you. So I'm going to put this ... it's your fault this is cut ... we're going to leave that on there [points to towel over the cut] and then the cuffing's not on as hard.

124. Mr AY protests and the officer says: 'I have to, mate'. Then to the other officers he says:

He's going to get cuffed down at the, ah ... We'll take it outside and we'll just sit on the stairs side by side. Hold him. Keep a hand on his wound. When we get down there, we'll cuff him down there.

125. The video ends with Mr AY being escorted into a van, still being held by officers. Throughout the entire video, Mr AY presents as calm and compliant, albeit that he is complaining about the pain in his wrist.

126. After arriving in the property area of VIDC, Mr AY was seen by IHMS. Mr AY says that the IHMS nurse told a Serco officer that Mr AY needed stitches but the Serco officer said that there was not enough time for stitches as he needed to be transported. The medical notes say:

Client seen in property after slashing his right wrist with a razor blade – incident not witnessed by IHMS.

Client is on the Curtin transfer list.

Wound is a clean slice about 5cm from the distal end of his right forearm. It is a clean cut, quite deep down to the fascia, no major blood vessel involvement. Not bleeding at time seen.

Wound cleaned with N/saline, dermabond glue and steristrips applied. Client asked to keep his wrists relatively straight during transport.

Unable to give tetanus or antibiotics as client was cuffed and taken to the bus.

Curtin contacted for f/u management.

127. It does not appear from the medical records provided by the department that IHMS was asked for, or gave, advice about whether Mr AY should be handcuffed for transport. It appears that the decision to handcuff Mr AY had already been made by the time he was seen by IHMS. The department said that:
- Due to [Mr AY's] behaviour, he was mechanically restrained and his risk rating was elevated to high for the purpose of aviation and escort safety for the duration of the flight.
128. It is clear from this comment that Mr AY was not previously considered to be a high risk detainee. The only basis given for increasing his risk level to 'high' was the self-harm incident that morning.
129. It also appears that IHMS considered that it would be appropriate to provide a tetanus vaccination and antibiotics but that they were unable to because of the need to take Mr AY to the airport in time for the flight to Western Australia. That is, the timing of the transfer was prioritised over the provision of appropriate medical treatment.
130. The Commission asked the department to provide copies of any documents relating to decisions authorising the use of mechanical restraints on Mr AY prior to boarding the aircraft, while on the aircraft and after disembarking the aircraft. The only document initially produced by the department that related to this issue is an email from Serco's Regional Manager – East to Serco Immigration Services which reads: 'Gents, Approved list of detainees requiring restraints'. There follows a list of 13 names including Mr AY. There is no other text in the message. That is, there is nothing in the message that says why restraints were being applied to these people. The email was sent at 2.00pm on the day that Mr AY was removed to Perth. That is, it was sent 3 and a half hours after Mr AY had already been removed from his room and handcuffed.
131. In response to my preliminary view in this matter, the department said that mechanical restraints were applied to Mr AY's wrists 'with the knowledge and approval of the department's NSW Regional Manager'. The Commission then sought documents relating to the approval from the NSW Regional Manager. In response, the department said:
- Specific approval in writing was not provided for the application of restraints to [Mr AY] during the transfer operation. The NSW Regional Manager, along with other Serco and departmental officers, were present in the Emergency Control Centre (ECC) to oversee the operation and provide direction, and was kept aware of [Mr AY's] circumstances throughout.

132. The department provided a copy of the log from the ECC that day commencing at approximately 6.30am and concluding at approximately 11.45am. Several things are significant from this log. First, it appears that at approximately 7.15am a decision was made to remove four detainees from the group being transferred 'due to contention with airline about wearing cuffs'. It seems that it was possible, in the context of this operation, for changes to be made at the last minute to exempt some people from being transferred. Secondly, Serco anticipated that Mr AY may engage in self-harm if force was used to enter his room. From 9.18am, two entries read:

0918: Still not having success with [Mr AY].

0920: JH recommends give until 0930hrs. Then give him formal direction. If he still refuses GP contact ECC to get permission for low impact use of force. Need to be careful as do not have visual of him and he may be preparing for self-harm.

133. Thirdly, following approval being given for the use of force and Mr AY engaging in self-harm, the log reports (contrary to the later more detailed medical advice from IHMS) that Mr AY has only 'a small superficial cut on his wrist'. Two minutes later, the log reports that 'once [Mr AY] has been cuffed and searched he will be taken in a vehicle to SKSA [Sydney Kingsford Smith Airport]'. There does not appear to have been any consideration given in that two minute period to whether it was appropriate for Mr AY to be handcuffed over his wrist wound. Fourthly, it was more than 20 minutes later that the log reports that Mr AY was being taken 'to medical to get wrist seen to'. That is, the decision to handcuff Mr AY was made prior to him obtaining medical treatment (where IHMS recorded that the cut was 'quite deep down to the fascia'). It does not appear from the log that the medical assessment from IHMS was provided to the ECC or that any further consideration was given to whether handcuffing Mr AY was appropriate.

134. There are no records of the captain or cabin manager on the flight requiring that Mr AY be restrained during the flight. The department has provided the Commission with some emails seeking details about the authorisation for Mr AY's restraint during the flight. An email from the department, apparently to the chartered service provider that arranged the flight to Western Australia, read:

I have fielded an enquiry from Serco about the VIDC charter of 3 April 2014. They are answering a complaint in relation to [Mr AY] who was restrained during that flight. He was not one of the 'Dangerous' PICs but Serco brought him to the aircraft in restraints due to his behaviour in the morning before the flight (he had barricaded himself in his room and self-harmed) and he remained restrained for the rest of the operation.

Serco suggest that [Mr AY] continued to be restrained throughout the flight as a precaution which was required and/or supported by the captain - as he had arrived in restraints and was therefore assessed as an ongoing aviation risk. Does that sound right?

Would you have a cabin manager's report with any evidence of this decision?

135. This version of events was not supported by the chartered service provider. The response to the department said:

I have reviewed all documentation and PIC form regarding the flight and [Mr AY].

Advice from the Captain and Cabin Manager is that when the Detainees as presented to the aircraft and boarded [Mr AY] was restrained due to an incident prior to transport to the aircraft. Once on board the aircraft in restraints [the chartered service provider] has no power to re-assess for the removal of restraints of a Person in Custody and therefore must remain as such for the duration of the flight and disembarkation.

I have no Captain Manager reports for this flight and I believe from discussions there was no trouble from this detainee during the flight.

136. Contrary to Serco's Operational Manual, there are no documents which suggest that specific authority was given by the aircraft captain/commander to use handcuffs on Mr AY during the flight. In fact, there is no evidence that the captain was consulted about whether or not Mr AY should be restrained. Instead, the email above suggests that Mr AY was restrained at the initiative of Serco and continued to be restrained only because he was restrained when he boarded and the chartered service provider considered that it had 'no power' to reassess this decision.
137. There is no indication that Mr AY exhibited any behavioural problems or that there was any assessment that he posed a risk to himself, others or property. The reference to Mr AY not being categorised as 'dangerous' appears to be a reference to the Airport Transport Security Regulations 2005 (Cth), referred to below. Contrary to the department's Detention Services Manual, the restraints were not removed from Mr AY 'once the threat has diminished and the officer believes that the detainee is no longer a threat to themselves, others or property'.
138. The handcuffs were not removed from Mr AY's wrists until he arrived at Curtin IDC, approximately 8 and a half hours after they were first applied. Reports provided by Serco indicate that Mr AY and 12 other detainees were handcuffed and loaded onto buses ready for transfer to the airport at 10.30am AEDT on the morning of the transfer. The buses left for the airport at 11.25am. The department has confirmed that Mr AY continued to be restrained during the ground transfer from VIDC to Sydney airport, the flight from Sydney to the west coast of Western Australia and the subsequent ground transfer to Curtin IDC. An escort observation log notes that the handcuffs were removed at 3.57pm local time in Western Australia (6.57pm AEDT), approximately 8 and a half hours after they were first applied.



139. The department suggests that the 'Office of Transport Security regulations' required Mr AY to be restrained for the entire period of his transfer. It appears that this may be a reference to the Airport Transport Security Regulations 2005 (Cth). However, a review of those regulations does not support this statement. Even for the transport of 'dangerous' persons in custody (which, as noted above, Mr AY was not), the regulations only provide the number of escorts that must be provided.<sup>62</sup> The regulations do not otherwise require the person to be restrained. Indeed, the form required for escorted travel asks: '**May it be necessary** to handcuff the person **at any stage** during the flight?' (emphasis added).<sup>63</sup> This is a long way from a mandatory requirement for handcuffing for the entire duration of a flight, particularly for someone not assessed as dangerous. During the course of the inquiry, the Commission asked the department to identify any other relevant regulations dealing with escorted travel. It did not do so. In response to my preliminary view, the department acknowledged that the Civil Aviation Regulations 1988 (Cth) do not require 'dangerous persons' to be mechanically restrained while being transported by air. The department agreed that its previous response incorrectly suggested that Mr AY was restrained for the duration of the flight under the requirements of the Airport Transport Security Regulations 2005 (Cth) and that those regulations provided that a chartered service provider had no power to reassess the removal of the restraints.
140. After arrival at Curtin IDC, Mr AY received medical treatment for his wrist injury the following day. He reported to the treating doctor from International Health and Medical Services that he was experiencing significant pain. The medical report of his initial consultation said:
- Self harm right wrist prior to being transferred to Curtin IDC <24h ago. Reports nil previous history of self-harm. Cut himself with a razor prior to boarding the bus. Reason: did not want to leave fiancée in Villawood. Spontaneous "he wasn't thinking".
- Did not receive ADT [diphtheria and tetanus vaccine] in NSW. Laceration closed with tissue adhesive (wound under low tension). Wound depth to fascia. Reports ++ pain.
141. Two days after the transfer, his medical report said: 'Area moist with serious ooze no puss collection noted. Surrounding skin inflamed up to 20cm from wrist.' Antibiotics and pain relief medication were prescribed.
142. The department claims that there is 'no evidence' that the application of mechanical restraints to Mr AY either 'contributed to or caused pain and discomfort' or was contrary to Serco's contractual requirements not to apply restraints in a manner likely to cause injury or serious discomfort. The department also claims that Mr AY's wrist injury was 'essentially superficial'. However, based on the submissions made by Mr AY, the video footage of the incident and the contemporaneous medical records by IHMS described in paragraphs 126 and 140 above, I am satisfied that this was more than a superficial wrist wound, that the application of mechanical restraints was likely to exacerbate this injury and cause serious discomfort, and that the application of mechanical restraints did in fact contribute to Mr AY's pain and discomfort.
143. Four days after the transfer, Mr AY's fiancée emailed the department asking for a review of Mr AY's detention placement and asking that he be transferred back to Sydney. She attached letters of support and a copy of their Notice of Intention to Marry.

144. Almost two weeks after the transfer, an IHMS report of a mental health consultation with Mr AY noted:
- Client would benefit from some feedback from DIBP re why he was sent to Curtin – as punishment? If client could get some answers to his questions it would in my opinion reduce the risk of this client repeating his self harm incident.
145. Mr AY was detained at Curtin IDC for less than a month and was then transferred back to VIDC in Sydney. He says that he was not told the reason why he was returned to Sydney after a short period of detention in the northwest of Western Australia. Curtin IDC was closed by the end of June 2015.<sup>64</sup>
146. The department says that Mr AY was one of around 150 detainees who were transferred from VIDC as a result of planned infrastructure works. It says that ‘a range of factors such as health, immigration pathway, legal matters [and] immediate family ties were considered prior to transfer’. No documents have been provided to the Commission about how these matters were taken into account in Mr AY’s case. The question of family ties seemed particularly relevant in his case. The department says that the reason for returning him from Curtin to VIDC was ‘primarily to reunite him with his family’ following a recommendation from Case Management at Curtin.
147. My findings are as follows:
- (a) This incident should have been filmed in its entirety rather than the video commencing after a planned use of force had already started.
  - (b) Serco should have sought approval in writing from the department for the use of handcuffs on each person to be transferred, setting out the reasons why handcuffs were requested for each individual, and both the request and the authorisation documents should have been retained.
  - (c) In the circumstances, handcuffs should not have been applied at all, and certainly not over a significant wrist wound where the client was not agitated, was not otherwise a high risk or dangerous detainee, and was compliant with instructions from Serco.
  - (d) After the self-harm incident, Serco should have sought advice from IHMS as to whether it was appropriate to handcuff Mr AY and this advice should have been recorded in writing and retained. If the advice from IHMS was that he should not be handcuffed, then consideration should have been given to either transferring him without handcuffs or not transferring him until he could obtain necessary medical treatment.
  - (e) If the captain of the charter service had a view about whether handcuffs should be applied to Mr AY, this should have been recorded in writing by Serco and retained.
  - (f) The necessity for the use of handcuffs on Mr AY should have been periodically reassessed and, consistently with the Detention Services Manual, restraints should have been removed ‘once [any] threat has diminished and the officer believes that the detainee is no longer a threat to themselves, others or property’.

- (g) The use of handcuffs contributed to Mr AY's pain and discomfort in circumstances where he had a serious wrist injury. This was contrary to Serco's contractual requirement not to use restraints in a manner likely to cause injury or serious discomfort to detainees.
- (h) In the circumstances the prolonged use of handcuffs, particularly over a significant wrist wound, was contrary to Mr AY's rights under article 10 of the ICCPR to be treated with humanity and with respect for his inherent dignity.

## 7.2 Case study: Mr BC

- 148. Mr BC complains that Serco officers used force against him in order to remove him from a bus in Darwin and onto a plane bound for Nauru, that the officers used handcuffs on him and that he was handcuffed for the duration of the flight to Nauru, being approximately 9 hours.
- 149. The use of force on Mr BC was filmed using a hand held camera, beginning while he was still on the bus shortly prior to force being used and ending after he had boarded the aircraft. That is, in this case Serco staff were careful to ensure that the entire incident was filmed. The Commission has reviewed the footage and considers that the level of force used was not inappropriate in the circumstances. The Commission has also reviewed records from the flight, including a log made by Serco of observations during the flight.
- 150. Mr BC was 47 years old when he arrived in Australia in December 2013 along with his two sons (one aged 14 and the other aged 16 or 17 years) and his younger brother (then 31 or 32 years old). They claimed to be stateless Rohingya from Myanmar. The family was transferred to Nauru pursuant to the Australian Government's regional processing arrangements. In February 2015, Mr BC and his sons were brought to Australia temporarily so that Mr BC could receive medical treatment.
- 151. The incident in question occurred in March 2015, when the Commonwealth sought to take Mr BC and his sons back to Nauru. Mr BC and his sons were taken by bus to Darwin International Airport. The department says that Mr BC refused to leave the bus to board the aircraft and that Serco staff negotiated with Mr BC for 15 minutes before the escort commander contacted the National Operations Manager requesting permission to use force to escort Mr BC from the bus, including the use of restraints. The department says that the captain of the flight asked that handcuffs be applied to Mr BC. This is supported by a note in the log made in the Serco Escort Operational Order. Approval to use restraints was granted 25 minutes later.

152. Based on a review of the video, Serco officers negotiated calmly with Mr BC; they explained that the captain had asked that he be restrained and asked him to voluntarily present his hands so that handcuffs could be applied. They explained that if he did not comply that they would have to use force. Mr BC was non-compliant and sought to prevent handcuffs being applied. Between three and five Serco officers applied force at various times over a few minutes in order to apply the handcuffs in front of his body. Once applied, the officers checked the tightness of the handcuffs. The amount of force used appeared to be no more than was necessary in the circumstances. Once the handcuffs were applied, Mr BC was walked off the bus and was escorted onto the plane. His sons were then escorted onto the plane without force being applied to them.
153. Handcuffs were applied to Mr BC at 5.25am just prior to boarding and remained applied during refuelling in Cairns and until 2.20pm (Darwin time) after the flight had arrived in Nauru and a property handover had been completed, a total of 9 hours. The log made by Serco indicates that the handcuffs on Mr BC were checked every 15 minutes during the flight. The log records that approximately 6.5 hours into the flight, Mr BC complained that it was hard to sleep with the handcuffs on. Otherwise, no concerns were recorded. Toilet breaks were offered on six occasions throughout the flight and refreshments were offered twice.
154. Mr BC made a complaint to Serco about the use of force and the use of handcuffs. Among other things, the response from Serco asserted that '[o]nce a Detainee has been restrained when entering the aircraft, it is a regulatory stipulation that they remain restrained for the duration of the journey'. I asked the department whether they agreed with this statement and, if so, to identify the relevant regulatory requirement. The department did not respond directly to this question and said that Mr BC was restrained at the request of the captain.
155. Regulation 309(1)(a) of the Civil Aviation Regulations 1988 (Cth) provides that the pilot in command of an aircraft, with such assistance as is necessary and reasonable, may take such action including the removal of a person from the aircraft or the placing of a person under restraint or in custody, by force, as the pilot considers reasonably necessary to ensure compliance with the *Civil Aviation Act 1988* (Cth) or the regulations in or in relation to the aircraft.
156. On the basis of the material provided to me, I am not satisfied that the force used on Mr BC was inappropriate in the circumstances. Force was necessary in order to ensure that Mr BC left the bus and boarded the flight. The degree of force used appeared to be proportionate in the sense that no more force was used than was necessary in the circumstances. It appears that restraints were applied at the request of the captain. I am not satisfied that the use of force on Mr BC was inconsistent with or contrary to his human rights.

### 7.3 Case study: Mr CE

157. Mr CE complains that he was handcuffed for more than 12 hours when he was transferred between Christmas Island IDC, via Perth to Melbourne. He was then flown to the Wickham Point immigration detention facility in Darwin but was not restrained for this leg.

158. Mr CE was 27 years old when he arrived in Australia from Vietnam in March 2013 as an unauthorised maritime arrival along with his brother. They were initially detained on Christmas Island before being transferred to Wickham Point in Darwin in July 2013. They were later transferred to Yongah Hill IDC and then back to Christmas Island in January 2014. The department says that Mr CE's security rating was 'low risk' during this period.
159. In February 2014, Mr CE's brother was transferred to Wickham Point again so that he could obtain medical treatment before being returned to Christmas Island in late 2014 or early 2015. Mr CE says that his brother made an escape attempt during one of his stays at Wickham Point. It does not appear that Mr CE was involved in any escape attempt.
160. The incident that Mr CE complains of occurred in August 2015 after he had been in detention for almost two and a half years. Ten people detained at Christmas Island were to be transferred by a chartered aircraft to different immigration detention facilities on the mainland. The Transport & Escort Operations Manager, Serco Immigration sought approval from the Acting Superintendent, Christmas Island IDC to use mechanical restraints on six of the people to be transferred. That is, some but not all of the detainees would be restrained. In the covering email, the Serco officer noted that six people, including Mr CE, would be restrained mechanically from North West Point IDC on Christmas Island to the airport, during boarding, for the duration of the flight and during disembarkation. The email seeking approval attached a Request for Services which set out details of the transfer.
161. The department said that mechanical restraints were applied to Mr CE's wrists in front of his body at about 4.00pm AEST (1.00pm Christmas Island local time) on the date of the transfer. The department says that Mr CE was in mechanical restraints for about 12 hours and 20 minutes until approximately 4.20am the following morning when the restraints were removed at Melbourne Airport. The department has provided the Commission with an Escort Operational Order which contains a log of part of Mr CE's transfer and shows that the restraints were removed at 4.21am in the department's holding rooms at Melbourne Airport. The department says that Mr CE was not restrained for the onward journey to Wickham Point in Darwin.
162. Mr CE says that he was distressed by this treatment.
163. The Commission asked the department why Mr CE was restrained when he was not a high risk detainee. The department said that:

Each movement is considered on a case by case basis with respect to the apparent risks of the movement. The Department approves or directs Serco to use mechanical restraints based on the perceived risks of the transfer operation, including the consideration that the movement may involve a number of detainees.

...

[Mr CE] was transported with several other detainees at the time of his transfer in August 2015 and the decision to mechanically restrain him during that movement was based on the assessed risk of the overall operation, not just his individual rating at the time.

164. It appears from this response that Mr CE's individual security assessment would not have been sufficient for him to be restrained but that a decision was made to restrain him because he was being transferred along with a number of other detainees who required restraints. No explanation has been provided about how Mr CE's involvement in the transfer incrementally increased the risk of the 'overall operation' in a way that justified him also being restrained. No explanation has been provided about why Mr CE was restrained while other detainees were not.
165. In particular, no explanation has been provided for why Mr CE was not flown from Perth directly to Darwin instead of flying almost all the way around Australia and spending 12 hours in handcuffs. Presumably if no restraints were required when he was flying from Melbourne to Darwin, then no restraints would have been required if he just flew straight to Darwin from Perth without the other detainees. In response to my preliminary view, the department confirmed that Mr CE was not restrained for the flight between Melbourne and Darwin because he was the only detainee being transferred and he was accompanied by two dedicated security escorts.
166. As noted above, the department's Detention Service Manual provides that:
- Restraint during escorted visits and scheduled travels only applies to detainees who have a serious or violent criminal history, those who have a history of escape, and those for whom the risk assessment indicates that they potentially pose a high risk. In practice this means that reasonable force and/or restraint will be determined following risk-management procedures.<sup>65</sup>
167. The Escort Operational Order records that on the date of the transfer Mr CE's escort risk assessment was 'medium' and his risk rating was 'medium'. The department provided the Commission with Mr CE's Security Risk Assessment immediately before and immediately after the transfer. Prior to the transfer, Mr CE's security rating was 'medium', however, a detailed review of his history in detention over the previous two and a half years shows an almost entirely clean record. There are only 10 incidents recorded. Eight of those incidents were pre-planned use of force by Serco on Mr CE during an escort. None of those incidents was in response to any specific conduct on Mr CE's part. One incident relates to a minor disturbance in the weights room on Christmas Island when Mr CE was present, but not himself involved in any aggressive conduct. The final incident relates to his participation, along with 156 other detainees in a hunger strike two years previously. Mr CE had never been involved in any incident of abusive or aggressive behaviour in two and a half years. He had never attempted to escape from detention. He had never had an intelligence report written about him. His engagement with Serco, the department and other detainee was described as '[u]sually polite and well behaved with staff and other detainees'.
168. However, on or about the date of the transfer, Mr CE's 'escape' risk rating was manually overridden from 'low' to 'medium'. No notes are provided on the amended risk assessment for the reasons for this manual override. Based on a review of his file, it appears possible that a manual override may have been made because Mr CE's brother had attempted to escape or because other Vietnamese detainees in the past have attempted to escape from detention.

169. From June to November 2014, nine months before the transfer where Mr CE was restrained, Mr CE's case reviews recorded that his security rating and that of his brother were 'high'. This was despite Mr CE not being involved in any significant incidents. The case reviews do not explain the reasons for this security rating and there is no support for such a rating based on a review of the details in his later security risk assessments. In Mr CE's case review for March 2014, his case manager recorded that 'Currently the minister is not considering Vietnamese cohort for BVE/CD release due to them being considered high risk'. The case review does not provide details on why such an assessment had reportedly been made for an entire ethnic or national group.
170. In response to my preliminary view, the department said that:
- The decision to restrain [Mr CE] was made due to his individual security risk assessment (security risk rating of 'medium'), coupled with broader operational considerations, including that the transfer operation included nine other detainees. In addition, intelligence information at the time was that a significant proportion of the Vietnamese cohort had a higher risk of absconding than other nationality cohorts.
171. It appears from the department's response that force was used on Mr CE, at least in part, because he was Vietnamese. I am concerned that one of the factors that the department took into account in restraining Mr CE (and potentially other Vietnamese detainees) was his nationality, particularly because his individual circumstances did not warrant it.
172. My findings are as follows:
- (a) Mr CE had not been involved in any incidents in detention which would have justified him being restrained during transfers, particularly in transit (eg during the course of a flight) where there was no prospect of escape. He had no history of any aggressive or violent behaviour.
  - (b) Not all of the detainees who were transferred from Christmas Island along with Mr CE in August 2015 were restrained. There has been no sufficient explanation of why Mr CE was selected out of this group to be one of those who were restrained.
  - (c) The fact that Mr CE was not restrained for the ongoing journey from Melbourne to Darwin supports the view that he was not considered to be a significant risk.
  - (d) There is no evidence that the captain of the aircraft asked that Mr CE be restrained.
  - (e) There were alternative, less restrictive, options available to the department, including transporting Mr CE separately from other detainees (in which case he would not be required to be restrained) and/or flying him directly from Perth to Darwin without restraints.
  - (f) In the circumstances, I am not satisfied that it was necessary to restrain Mr CE for more than 12 hours during the transfer from Christmas Island to Melbourne via Perth. I consider that the continuous use of restraints on him for this period was contrary to his rights under article 10 of the ICCPR to be treated with humanity and with respect for his inherent dignity.

## 8 Use of handcuffs in travel to court and medical appointments

173. As noted in section 5 above, over the course of 2017 the Commission visited all Australian immigration detention centres and interviewed a large number of detainees. A recurring complaint was about the use of handcuffs when on escort from detention facilities.
174. In a number of cases, detainees said that they had refused to be handcuffed to attend external medical appointments and as a result were not permitted to leave the detention centre. In some of these cases, detainees said that they were asked to sign a form saying that they had 'refused treatment'.
175. During the course of the inspection visits, the Commission repeatedly heard examples of mechanical restraints being left on while a person was receiving medical treatment or undergoing diagnostic tests (such as x-rays).<sup>66</sup> In some cases, restraints were reportedly used in circumstances where there appeared to be limited risk of escape or harm to others. For example, some people indicated that they had been restrained even when receiving treatment in mobile clinics that remained parked inside the perimeter fence of an immigration detention facility.
176. The people who reported these concerns to the Commission during those inspection visits did not make formal complaints and, as a result, the Commission is not able to verify those particular reports. This report will consider other specific examples of cases involving the use of handcuffs during escorts, including for the purpose of attending medical appointments, and the appropriate use of restraints in these circumstances.
177. In some detention facilities, local Superintendents have decided that restraints should not be used on escort in particular circumstances.
178. For example, during the Commission's inspection of Yongah Hill Immigration Detention Centre in May 2017, facility staff reported that they had made efforts to reduce the use of mechanical restraints when people were being escorted outside the detention facility.<sup>67</sup> Staff said that it was rare for the Superintendent to authorise the use of restraints when people were escorted to medical consultations. The department said in response to the Commission's report about Yongah Hill IDC that it is extremely rare for detainees in the Western Australian region to be restrained in a vehicle or a medical facility.<sup>68</sup> I commend the Superintendent and management of Yongah Hill IDC for what appears to be a more nuanced approach to the use of restraints, with a focus on ensuring that restraints are not used in cases where they are not necessary. I consider that the practices adopted in Western Australia may offer useful lessons for the broader detention network.



179. The Commission also understands that Australian Border Force staff at Brisbane Immigration Transit Accommodation (BITA), on instructions from the Superintendent, have recently established a Standard Operating Procedure (SOP) in partnership with the Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT). QPASTT was particularly concerned that clients who required torture and trauma counselling could be re-traumatised if they were handcuffed to attend appointments, and that this was inconsistent with the therapeutic goals of the counselling. The Commission understands that the effect of the SOP is that the clients of QPASTT are no longer required to be mechanically restrained on escort to and from face to face counselling sessions at the Woolloongabba office of QPASTT. Further, clients will not be restrained while in attendance at that office and Serco officers in uniform will not be permitted in the office. Prior to finalising this new procedure, the ABF conducted a site audit of the physical premises of the Woolloongabba office to satisfy themselves that this protocol could be carried out consistently with the requirements of security. All BITA clients of QPASTT are now seen at that approved location. The Commission understands that if there were a significant security concern that would otherwise have required a client to be restrained on escort to QPASTT's offices, the SOP provides that QPASTT would consider providing telephone-based counselling rather than face to face counselling if the client does not want to be transported in restraints. I commend the Superintendent and management of BITA for this initiative. This SOP may be a useful model that could be applied in relation to transport to and from torture and trauma counselling sessions in other locations around Australia.
180. In response to the comments about this issue in my preliminary view, the department said:
- [W]ith the exception of Queensland and NSW, IHMS has successfully negotiated with T&TC [Torture and Trauma Counselling] service providers to facilitate T&TC sessions onsite. In Queensland and NSW, detainees attending offsite T&TC are not mechanically restrained during their appointment, but may be transported to and from appointments in restraints. Where restraints are deemed appropriate for the transport of detainees, the Department provides notification to the T&TC service provider that a detainee will be required to attend in restraints, however, restraints will be removed prior to the appointment.
181. Two case studies about the use of restraints to attend external appointments are considered in more detail below. In summary:
- (a) Mr DB was required to wear handcuffs to attend a number of court appointments in relation to an alleged assault. Given that the allegation was one of violence, I am not satisfied that the requirement for mechanical restraints was inappropriate. However, there were process problems in seeking approval for restraints to be used. On two occasions, restraints were used prior to Serco receiving approval for their application. On another occasion, Mr DB was not medically cleared by IHMS prior to restraints being used as there were no IHMS staff on site. Mr DB was ultimately acquitted of the charges.

- (b) During a subsequent court appearance on an immigration matter, handcuffs were not used on Mr DB. However, a few months later Mr DB was again required to wear handcuffs in order to attend external medical appointments. Having considered in detail Mr DB's security assessments and the incidents he was involved in while in detention, I find that this requirement was not reasonable in the circumstances or proportionate to relevant risks. I am particularly concerned that there do not appear to be any documents that consider whether the requirement that Mr DB be restrained was appropriate given the medical risks that he faced if treatment was not provided. I find that the requirement that he be handcuffed to attend these medical appointments was inconsistent with his right to be treated with humanity and with respect for his inherent dignity.
- (c) Mr Sayed Abdellatif was required to wear restraints to attend medical appointments in October and November 2015. At the time he had a 'high' security risk assessment as a result of an alleged threat to staff. He refused to wear restraints and did not attend these appointments. The department subsequently reviewed and downgraded his risk assessment. On the material available to me, I am not satisfied that the requirement that he be restrained was inappropriate.

## 8.1 Case study: Mr DB

182. Mr DB was detained at Wickham Point immigration detention facility from February 2014. He complains about requirements to wear handcuffs while being transferred from Wickham Point to court and to attend medical appointments.

### (a) Criminal allegations

183. Mr DB was alleged to have assaulted a Serco officer in July 2014 and was required to attend the Darwin Court of Summary Jurisdiction. He was represented by the Northern Territory Legal Aid Commission. He complains that he was required to wear handcuffs on six occasions that he was transferred between Wickham Point and court. The handcuffs were metal and his hands were cuffed in front of his body. He was found not guilty on 20 April 2015.

### (b) Immigration matter

184. Mr DB also complains that, after being found not guilty in relation to the assault allegation, he was told that he had to wear handcuffs when attending court for an immigration matter relating to his application for a protection visa. He says that he refused to attend the hearing if he was required to wear handcuffs. He says that a Serco officer called the court and that following that call he was allowed to attend court without handcuffs.

**(c) Medical matters**

185. Mr DB complains about a requirement to wear handcuffs to attend medical appointments outside Wickham Point in late 2015 and early 2016. Mr DB had two medical issues that required referral to medical specialists outside of the detention centre. The first issue involved appointments to scan his liver to monitor the impact on his organs of his Hepatitis B, the second issue involved bladder problems.

Hepatitis B monitoring and liver scans

186. Mr DB was diagnosed with Hepatitis B before arriving in Australia. In April 2014 he and his wife were transferred from Villawood IDC to Wickham Point. In May 2014 he was referred to Darwin Medical Imaging for an ultrasound of his abdomen. He was not restrained for this external appointment.
187. He attended an appointment with an IHMS GP in August 2015 to review his Hepatitis B care plan. The GP recommended a repeat pathology and liver ultrasound. An appointment was booked with a medical imaging clinic in Humpty Doo for 8 September 2015. Mr DB refused to attend the appointment because of the requirement that he be handcuffed during the transfer.
188. During an IHMS appointment on 24 September 2015, he again refused a referral to a liver clinic because of the requirement that he be handcuffed during the transfer.
189. Mr DB says that Serco wanted him to wear handcuffs in order to go to hospital. He says that he refused to wear handcuffs. He says that he complained to his case manager but that she was not interested.
190. In relation to this first issue, the department says:

On 24 September 2015 [Mr DB's] GP noted his viral load was raised, but his liver function tests were stable. [Mr DB] declined a referral to see a gastroenterologist for further review. [Mr DB] did not wish to be handcuffed when attending appointments. The GP asked [Mr DB] to consider the referral further and to discuss concerns with his departmental Case Manager.

On 29 September 2015, [Mr DB's] GP submitted a referral to the gastroenterologist, in the event [Mr DB] decided to attend. This appointment was booked for 2 February 2016.

On 29 January 2016, [Mr DB] advised his GP he will continue to refuse to go to the gastroenterologist appointment as he does not wish to be handcuffed.

On 2 February 2016, [Mr DB] refused to attend the gastroenterologist appointment.

On 3 February 2016, the gastroenterology clinic wrote to [Mr DB] recommending he attend an appointment to discuss his health issue.

Bladder problems

191. The bladder problems were first diagnosed in November 2015. Mr DB attended an IHMS appointment complaining that he could not fully empty his bladder and that this problem had been occurring for around 3 months. IHMS recommended a urinary tract ultrasound to assess his bladder capacity and prostate size. Mr DB says that Serco again wanted him to wear handcuffs in order to go to the imaging centre in Humpty Doo. He says that he refused to wear handcuffs and was therefore not permitted to attend the appointment.

192. In relation to this second issue, the department says:

On 1 January 2015, [Mr DB] mentioned a bladder problem, with abdominal pain, to a GP. Urinalysis was performed with normal results. [Mr DB] was given medication to ease the symptoms.

On 19 November 2015, [Mr DB] discussed a bladder issue [with] his GP again. The urine test on this date was negative, however, he was referred for an ultrasound for further investigation. ... [Mr DB] refused to attend the ultrasound as he did not wish to be handcuffed.

On 29 January 2016, [Mr DB] complained to his GP of bladder issues and the GP discussed [Mr DB's] refusal to attend his ultrasound appointments. [Mr DB] ... indicated he cannot accept being handcuffed whilst attending external appointments. There has been no further mention of this issue.

193. Mr DB's first offsite appointment for an ultrasound scan was booked for 24 November 2015. As noted above, Mr DB refused to be handcuffed and as a result was not permitted to attend the appointment. IHMS records indicate that Mr DB was asked to sign a 'Refusal of Treatment' form. The Refusal of Treatment form states:

I [name] refuse to accept the Medical treatment that [name of Doctor / Registered Nurse] who is an employee of contractor of International Health and Medical Services (IHMS) has recommended to me.

The consequences of me refusing to accept treatment from IHMS has been explained to me and I fully understand that my health may be adversely affected if I do not comply with treatment.

I take full responsibility for refusing treatment and do not hold IHMS responsible in any way for what may happen if I stop taking their recommended treatment.

194. Mr DB refused to sign the form. Mr DB says that he did not refuse treatment, rather, he wanted treatment but refused to be handcuffed. The IHMS notes for that day say 'appointment will not be rescheduled until issue resolved between client and security unit'. There do not appear to be any records that indicate that advice was sought by Serco from IHMS about the seriousness of Mr DB's condition or the necessity for the medical treatment sought.

195. The department says that if a detainee declines to sign a Refusal of Treatment form, IHMS will still record the refusal in the person's health care record. In response to my preliminary view, it also said:

If a detainee claims to refuse the use of mechanical restraints when appearing to refuse consent to medical treatment, then IHMS will clarify whether the detainee is actually refusing medical treatment or not. This is because IHMS must give the detainee sufficient information to make a decision on the treatment being offered and this must be documented in the health care record. ...

The refusal by a detainee to attend a medical appointment, for any reason, is not a refusal by the Department or its service providers to provide that treatment.

196. Mr DB refused to be handcuffed to attend further offsite appointments in February and May 2016. On 12 May 2016, IHMS warned him about the medical risks of not attending these appointments. IHMS notes for 12 May 2016 provided:

Refused to go for his US [ultrasound] and liver clinic RDH [Royal Darwin Hospital] in February due to issue with mechanical restraint (handcuff). RDH has rescheduled the appointment again in a few weeks time (31/5/16), he needs to have repeat path (last was done in September 15) and liver US prior to this appointment.

Explained the importance of this. Even though he feels well, he still needs regular follow up with blood test and liver US. Explained that Hepatitis B can lead to liver failure and liver cancer and patient[s] usually have to wait to see specialist therefore should try his best to attend when appointment given.

I explained that IHMS has no control over operational security procedure of Serco and my understanding is that he is considered high risk by Serco.

He say he will attend the blood test tomorrow but still disagree to go off site with handcuff. Advised him we will keep the appointment and ask him to think / consider his decision.

197. IHMS notes for 23 May 2016 provided:

Client brought to medical clinic prior to departure for medical imaging appointment scheduled for liver U/S.

Due to security rating of High Risk by relevant stakeholder, client refuses to attend due to having to wear mechanical restraints (handcuffs).

Medical consequences were explained in depth by GP last week to ensure attendance today. Client had agreed last week to attend, hence new appointment booked.

Explained that no further appointments were to be booked as is his own responsibility for health regardless of the use of mechanical restraints.

Also explained to client that the use of mechanical restraints was due to his past behaviour and was thus judged high security risk by security stakeholder. Explained that this process is not under the control or influence of IHMS.

198. Again, there do not appear to be any records that indicate that advice was sought by Serco from IHMS about the seriousness of Mr DB's condition or the necessity for the medical treatment sought. The IHMS notes suggest that their advice about the potential health outcome for a detainee is irrelevant when Serco is assessing whether to refuse to take a detainee to an external medical appointment as a result of a detainee's refusal to wear handcuffs during the transfer.

199. It appears from Mr DB's medical records that in September 2016 Mr DB attended an ultrasound appointment at Northern Ultrasound in Northam, Western Australia. This clinic is located close to Yongah Hill IDC. It appears that Mr DB was transferred to Yongah Hill IDC prior to this appointment. It is not clear whether Mr DB was required to wear mechanical restraints for this appointment. As noted above, staff at Yongah Hill IDC reported to the Commission that the Superintendent has taken steps to ensure that detainees are rarely restrained when being escorted to medical consultations.

**(d) Consideration**

200. The department says that it has records of Mr DB being required to wear mechanical restraints on at least two occasions prior to 20 October 2014. The department says that there may have been other occasions when Mr DB was required to wear restraints where records have not been kept.
201. The department says that Serco improved its record keeping at Wickham Point in relation to authorisations for the use of mechanical restraints from 20 October 2014. It says that after 20 October 2014 there were no other pre-planned external appointments carried out for Mr DB with the exception of his court visits. On each occasion after 20 October 2014 (with the exception of his court appearances), the department says that Mr DB refused to leave the detention facility, citing his objection to the use of mechanical restraints.
202. The department says that:
- All detainees who have high risk ratings are required to be mechanically restrained outside the detention facility. As [Mr DB] has been assessed to have a high security risk rating, he is required to be mechanically restrained at all times outside the Wickham Point Immigration Detention Centre. This includes journeys to and from hospital.
203. In response to my preliminary view, the department said that while health advice was taken into consideration in determining whether handcuffs should be applied, the decision by the Superintendent that Mr DB be handcuffed took into account the department's safety and security responsibilities.
204. The department has provided the Commission with Security Risk Assessments dated 29 January 2015 and 2 June 2016. In January 2015, Mr DB's overall risk rating was 'high'. Ratings were also given for various kinds of risk. He was assessed as a 'low' risk of demonstration, escape and self harm. He was assessed as a 'high' risk of aggression/ violence and criminal profile.
205. As at 29 January 2015, Mr DB had been in immigration detention for approximately 11 months. During that time, he had been involved in 13 incidents of 'abusive/aggressive behaviour'. Some of these are relatively minor, for example: 'detainee became abusive towards a Serco staff member by speaking to her in a raised voice using bad language and an aggressive tone' or 'detainee was abusive towards Serco officer'. He had been involved in six incidents categorised as a 'minor' assault. The most serious incidents listed on Mr DB's Security Risk Assessment as at 29 January 2015 were two incidents categorised as 'serious' assaults.
206. The first assault rated as 'serious' occurred on 1 July 2014. A fire alarm had been activated in the Surf compound shortly before 3.00am. Detainees were asked to evacuate to the soccer oval. Mr DB instead made his way to the designated smoking area and told an officer that he wanted to have a cigarette. The officer stopped him and directed him to the soccer oval. According to Mr DB, the officer tried to knock a cigarette from his hand. According to a report by the officer, Mr DB 'became agitated and attempted to strike' the officer before Mr DB's wife intervened and placed herself between Mr DB and the officer. Again according to the incident report by the officer, Mr DB 'reached [past] his wife and was able to scratch me under the right eye'. It appears that the Northern Territory Police were called and Mr DB was charged with assault. He was ultimately found not guilty on 20 April 2015.

207. The second assault rated as 'serious' occurred exactly 6 months later on 1 January 2015. It involved Mr DB throwing a plastic chair at another detainee in the mess. According to Serco incident reports, this action was in retaliation for an assault by that detainee on Mr DB earlier in the day. Again, a fire alarm had been activated, this time shortly after 2.30am and detainees in the Surf compound were asked to evacuate. Mr DB attempted to return to his room instead and was restrained by a number of Serco officers. While he was being restrained by those officers, another detainee approached and, according to the Serco incident reports, this detainee struck Mr DB 'with significant force on the left hand side of his face three times'. According to the incident reports, the other detainee considered that Mr DB's refusal to evacuate had compromised the safety of his pregnant wife. It was this assault on Mr DB that prompted him to later throw a plastic chair. Northern Territory Police were contacted but it does not appear that any further action was taken by them.
208. The department has produced email authorisation for the use of restraints in transfers to court on four occasions, namely on 27 October 2014, 30 January 2015, 20 April 2015 and 27 August 2015.
209. Incident reports for these court transfers suggest that mechanical restraints were used on the first three occasions. On the last occasion, only the enhanced escort position (EEP) was used. EEP is an arm and elbow lock used to escort people. EEP was previously considered to be a 'use of force' incident and required an incident form to be completed. The department says that from 1 October 2015, it amended Serco's incident reporting requirements such that Serco was no longer required to report EEP as a use of force incident nor seek the department's approval in relation to EEP prior to it being used. The department says that this change took into account a recommendation from the Commonwealth Ombudsman to cease the practice of requiring incident reports for all pre-approved use of EEP. The department says that it continues to expect Serco to abide by legislative and policy requirements when applying use of force and that it 'requires Serco to report its use of EEP to the Department nationally'. It is not clear what form these national reports take.
210. Significantly, it appears that in two instances approvals for the use of mechanical restraints on Mr DB were only given after the transfers had already begun. That is, transfers outside detention involving the use of mechanical restraints had commenced without approval having been obtained first:
- In the case of the second transfer, on 30 January 2015, the incident report shows that Mr DB was placed in mechanical restraints when leaving Wickham Point. The report says that he arrived at Darwin Magistrates Court at 12.31pm. By 1.10pm he was seated in the waiting room at the court house. Approval for the use of mechanical restraints was only given by email at 1.14pm by the Compliance and Detention Operations Lead at the department (who was also based in the Northern Territory).

- In the case of the third transfer, on 20 April 2015, a request for approval to use restraints had been made by Serco a day in advance. It appears that approval had not been given by the morning of the escort. At 7.58am a follow up email is sent noting that 'the escort is about to leave'. The incident report and accompanying use of force report each indicate that Mr DB was placed in mechanical restraints at 8.23am. Approval for the use of mechanical restraints was only given by email at 8.33am by the Compliance and Detention Operations Lead at the department.
211. In the case of the third transfer, the use of force report notes that '[Mr DB] was not medically cleared by IHMS due to no IHMS on site at the time of departure'.
  212. Had the requests for the use of handcuffs on Mr DB been properly made in advance of the use of force, I consider that these requests would have been justified as proportionate. At the time, Mr DB was subject to charges of assault. It was on the third court visit that he was acquitted of these charges. Mechanical restraints were not used on the fourth visit, which appears to have related to an immigration matter rather than a criminal matter.
  213. The approval granted on the fourth occasion, 27 August 2015, notes that restraints were approved for transit to and from court, but not in the court room itself. It says that 'the NT Chief Magistrate has raised issues regarding the use of restraints in the court and our acting Regional Commander will be meeting with him in the near future'. In fact, it appears from the incident report that mechanical restraints were not used for this transfer. Instead EEP was used for two minutes in escorting Mr DB from the Serco vehicle to the court room prior to court, and for two minutes in escorting him from court back to the Serco vehicle after court.
  214. By the time of the risk assessment in June 2016, Mr DB had been acquitted of the criminal charges and his criminal profile risk had been reduced from 'high' to 'low' and his aggression/violence risk had been reduced from 'high' to 'medium'. His risk of escape remained 'low'. However, Serco maintained a 'high' risk assessment for 'escort risk'. It seems likely that the changes to these risk assessments would have been made sometime after the acquittal on 20 April 2015 and would have been the risk ratings that applied at the time of his scheduled medical appointments in late 2015 and early 2016.
  215. The department has produced email authorisation for the use of force in transfers to medical appointments on five occasions, namely on 23 April 2014, 16 May 2014, 8 September 2015, 23 November 2015 and 2 February 2016.
  216. The first two approvals in April and May 2014 were only for EEP. These transfers to medical appointments at Darwin Medical Imaging took place and Mr DB does not complain about them. Although Mr DB was categorised as 'high risk', approval for mechanical restraints was not sought. Instead, approval was sought and obtained for EEP which was used for between 1 to 2 minutes in transferring Mr DB from a vehicle into the imaging centre and on leaving the imaging centre and getting into a vehicle to return to Wickham Point.
  217. The last three authorisations, in September and November 2015 and February 2016, were for the use of both EEP and mechanical restraints. These transfers did not take place because Mr DB objected to the requirement to wear handcuffs.



218. I find that the requirement for Mr DB to wear handcuffs to attend external appointments at medical centres in late 2015 and early 2016 to have abdominal scans carried out was not reasonable in the circumstances or proportionate to relevant risks. This is for a number of reasons:
- (a) Mr DB had attended medical appointments while detained at Wickham Point in April and May 2014 without incident.
  - (b) By late 2015, Mr DB had been acquitted of the alleged assault on a Serco officer and his criminal record profile had been returned to 'low'.
  - (c) The only other 'serious' incident of aggression or violent conduct recorded against Mr DB was under circumstances of significant provocation – it followed an incident where he was repeatedly struck in the face by another detainee while being restrained by Serco officers.
  - (d) At all times, Mr DB was assessed as a low risk of escape.
  - (e) IHMS had warned that there were potentially serious consequences for Mr DB if he did not receive the scheduled medical treatment.
219. I am particularly concerned that there do not appear to be any documents that consider whether the requirement that Mr DB be restrained was appropriate given the medical risks that he faced if he was not provided the treatment that was recommended by his doctors. IHMS records repeatedly state that they have no control or influence over the question of whether or not Mr DB would be restrained. It appears that there was an attempt to shift the responsibility for any risks onto Mr DB by encouraging him to sign a 'Refusal of Treatment' form in circumstances where he was not refusing treatment, he was refusing to be handcuffed.
220. In these circumstances, I find that the requirement that Mr DB be handcuffed to attend these medical appointments and the refusal to allow Mr DB to attend these medical appointments unless he was handcuffed amounted to a failure to treat him with humanity and with respect for his inherent dignity, contrary to article 10 of the ICCPR.

## 8.2 Case study: Mr Sayed Abdellatif

221. Mr Sayed Abdellatif was the subject of a human rights inquiry by the Commission in 2014.<sup>69</sup> The circumstances of his detention and that of his family were considered in detail in that report. Mr Abdellatif is detained at Villawood Immigration Detention Centre. He has been administratively detained for more than five years.
222. Mr Abdellatif complained about two incidents in October and November 2015 when he had medical appointments outside of the detention centre. He did not disclose to the Commission the nature of the first appointment. The second appointment was for an ultrasound. On each occasion he was told in advance by Serco that he would be required to wear handcuffs to attend the appointment. Mr Abdellatif refused to wear handcuffs and as a result did not attend the medical appointments.

223. Mr Abdellatif says that he is aware that handcuffs are only applied to people who are considered to be high risk and he says that he was not informed that he was considered high risk.
224. In response to the Commission's inquiry, the department said that as a result of an incident in September 2015, Mr Abdellatif's risk rating was increased to 'high'. The department alleged that Mr Abdellatif had made threats to staff at the detention centre. Mr Abdellatif denies this. The department says that the proposal was for restraints to be used for transport to and from the medical centre but not during the consultation itself.
225. The department says that Mr Abdellatif's risk rating was reviewed in December 2015 and was downgraded. It said that '[a]lthough each request to apply mechanical restraints is assessed on a case by case basis, it is likely that the use of restraints would not be sought for future escorts'.
226. While I agree that it is important for risk assessments to be conducted on a case by case basis, I reiterate my concern about the use of mechanical restraints for medical appointments unless this is clearly necessary to prevent reasonably anticipated escape or violent conduct.
227. On the basis of the material available to me, I am not able to be satisfied that the requirement by Serco to use handcuffs on Mr Abdellatif in October and November 2015 was inappropriate.
228. During the course of this inquiry, Mr Abdellatif said that a similar incident occurred on 17 October 2017. He said that he has been diagnosed with Crohn's disease, an inflammatory bowel disease, and had been regularly seeing a specialist at Liverpool Hospital. He said that on 17 October 2017 he had symptoms of pain and bleeding and that a doctor at the IHMS medical centre at VIDC advised him to attend the emergency department at Liverpool Hospital. He says that a Serco escort arrived two and a half hours later and said that he needed to be handcuffed. Mr Abdellatif said that he refused to be handcuffed and as a result was not taken to hospital. He said that he was asked to sign a 'responsibility document' but he refused to do so. He said: 'I told them that I do not refuse to go, I refuse to be handcuffed'.
229. Mr Abdellatif's allegations are supported by copies of medical records from IHMS that he provided to the Commission. At a consultation on 17 October 2017, a GP noted Mr Abdellatif's history of Crohn's disease (27 years) and that his last colonoscopy was done in 2015. Mr Abdellatif presented with generalised abdominal pain, a bloated and distended abdomen and tiredness. He had bowel motions 'accompanied by yellow mucosa and fresh blood'. The GP diagnosed this as a flare-up of his inflammatory bowel disease and recommended review by the emergency department of a hospital.
230. A little over an hour later, the same GP observed:
- Abdellatif refused to go to hospital after transport was organised.
- He did not want to be handcuffed as he is not [a] criminal.

When I explained to him [that] this is the rule of detention centre and that is for everyone, still not happy to go to ED [emergency department]

He did not sign the refusal of treatment form when asked and left the clinic.

231. A primary health nurse made notes to the same effect:

Client refused to go to hospital against medical advice because he did not want to be handcuffed. Client also refused to sign the refusal of medical treatment form. Dr [ ] was aware and present at the time of refusal. Client was advised of the necessity of treatment, and should go to hospital. Client again refused.

232. Medical records show that Mr Abdellatif's symptoms continued.

233. The new complaints made by Mr Abdellatif were made after his complaint had been referred for possible reporting and after the Commission had sought a detailed response from the department about a range of use of force matters including Mr Abdellatif's original complaints. Given the timing of this new incident and the stage that this inquiry had reached, the Commission did not seek a further response from the department about this incident. I do not make any findings about this incident. I note that the practice of asking detainees to sign a 'Refusal of Treatment' form has been raised in the context of the complaint by Mr DB above and will be considered as part of that complaint.

## 9 Use of spit hoods and face masks

234. The Commission received a complaint about the use of a face mask on a detainee during an operation in which the detainee was being removed from Australia.

235. During the course of the Commission's inquiry, the Commission asked for a photograph of the kind of mask that was used. The department provided the Commission with two photographs of a spit hood called 'The TranZport Hood' manufactured by The Safariland Group. An image of the hood from marketing material produced by Safariland appears below. This is not an image of the complainant.



The TranZport Hood manufactured by Safariland.  
Source: [www.safariland.com](http://www.safariland.com).

236. However, in response to my preliminary view in relation to this inquiry, the department said that it had provided photographs of the spit hood in error. It said that, while spit hoods are approved for use in transporting detainees, it was not a spit hood that was used on this complainant but rather a 'surgical mask'. The department said that spit hoods were only approved for use in June 2015, several months after the complainant had been removed from Australia.
237. Given that spit hoods are an approved instrument of restraint, I make a number of comments below about their use before considering the particular complaint about the use of a face mask.
238. In early August 2016, the Australian Border Force issued a media release about the use of spit hoods in the immigration detention network.<sup>70</sup> The media release followed a *Four Corners* program broadcast on the ABC the previous week about the use of restraints including spit hoods in juvenile detention centres in the Northern Territory,<sup>71</sup> which became the catalyst for the Royal Commission into the Protection and Detention of Children in the Northern Territory.<sup>72</sup>

239. The ABF said that spit masks or spit hoods may be used within the Australian immigration detention network where there is a need to protect fellow detainees, staff, officers and the general public from the risk of being spat on or bitten.<sup>73</sup> It said that spitting carried the threat of transmission of biological contaminants and diseases such as HIV and Hepatitis C and that the use of spit hoods prevents a detainee from spitting saliva or blood. It said that spit hoods had not been used on minors and were not used as a means of behavioural control. It said that the spit hoods used in the immigration detention network were the same as those used by law enforcement agencies and that they did not restrict the wearer's vision.
240. The department's Detention Services Manual makes clear that: '[w]hether mechanical or otherwise, only items [of restraint] approved by the Secretary of the Department are to be used in an immigration detention facility'. Similarly, Serco's Operational Safety Policy & Procedure Manual provides that: '[o]nly restraints specifically approved by DIBP will be used within the Immigration Detention environment'.
241. The Commission asked the department to provide it with copies of all policy, procedure, guideline and training documents produced by or for the department or Serco since 1 January 2014 relating to:
- the use of force
  - the use of restraints
  - the use of spit hoods.
242. The department provided copies of Serco training documents on the planned and unplanned use of force, the use of flexi-cuff restraints and the use of mechanical restraints. No documents were produced in relation to the use of spit hoods. The use of spit hoods is not referred to in the department's Detention Services Manual or Serco's Operational Safety Manual. It appears from the department's response that there are no policies, procedures, guidelines or training documents about the use of spit hoods. The only relevant document that the Commission has been able to locate is the media release by the ABF referred to above.
243. I am concerned that the department has approved spit hoods for use in circumstances where Serco officers were apparently not provided with any training in their use, including in assessing whether or not the use of a spit hood is appropriate.
244. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment has published guidelines about the deportation of foreign nationals by air.<sup>74</sup> One of the key recommendations is ensuring that the use of force or means of restraint capable of causing positional asphyxia should be avoided whenever possible. This recommendation is primarily aimed at ensuring that detainees are not placed in a position in an aircraft seat where they are obliged to bend forward with their head between their knees in a position that strongly compresses the ribcage. This was the way in which Mr Jimmy Mubenga died in October 2010 as he was being removed from the United Kingdom to Angola.<sup>75</sup> His hands were cuffed behind his back and he was held in a 'head down' restraint position in a chair at the back of an aircraft.

245. More generally, the CPT has recommended that there be an absolute ban on the use of means likely to obstruct the airways (nose and/or mouth) partially or wholly. This includes restraint methods reported on by CPT including 'gagging the mouth and/or nose with adhesive tape, putting a cushion or padded glove on the face, pushing the face against the back of the seat in front, etc'.<sup>76</sup> It seems possible that the use of masks or hoods on detainees may also fall into the same category.
246. Beyond the risk that masking or hooding may present to detainees, it is clearly a method of restraint that is degrading. Unless it can be demonstrated as necessary in the circumstances and proportionate to particular risks faced, it is likely that the use of face masks or spit hoods on people in custody will be contrary to the right to be treated with humanity and with respect for the inherent dignity of the human person.
247. In the case study that follows, a face mask was used during a removal in circumstances where there had been no threat by the detainee to bite or spit and where there was no evidence that the detainee had any communicable disease. I find that the use of a face mask in these circumstances was contrary to his rights under article 10 of the ICCPR.

## 9.1 Case study: Mr EJ

248. Mr EJ complains that he was forced to wear a face mask during an attempt to deport him to China on 19 December 2014. The attempted deportation was abandoned after a protest from passengers on the plane. Mr EJ was successfully deported to China in February 2015. As noted above, during the course of the inquiry the department initially indicated through the provision of photographs that Mr EJ was required to wear a spit hood. However, in response to my preliminary view, the department clarified that the kind of mask that Mr EJ was required to wear was a 'surgical mask' and not a spit hood.
249. Mr EJ was 40 years old at the time of the incident.
250. The department has provided a series of emails relating to the approval to use force on Mr EJ during his deportation. The emails show a number of requests for restraints of steadily increasing severity and duration.
251. The first email was from Serco to the department on 11 December 2014. At that time, Mr EJ was assessed as being 'medium' risk. It was noted that he had not been involved in any incidents while in detention. He was assessed as being 'a possible flight risk given his unwillingness to depart and length of time in the community'. Approval was sought for the use of EEP in all non-secure areas of the escort during his removal.
252. On 12 December 2014, a departmental officer replied noting that pre-approved use of EEP in non-secure areas had been approved in writing by an officer in Detention Operations East. The department asked: 'Could you please advise why this escort is listed as Medium Risk if pre-approved EEP has been sought'.

253. An hour later, Serco responded saying that '[Mr EJ] has been upgraded to HIGH RISK (see attached SRAT [Security Risk Assessment Tool]). I have advised [redacted] and amended the EOO [Escort Operational Order] to reflect the change in the risk rating'. The email did not provide any explanation for the change in the risk rating.
254. A departmental officer responded, saying that the escort had been approved in writing as a High Risk Escort by the Director of Detention Operations East.
255. On 17 December 2014 at 10.48am, Serco sought approval from the department 'for application of Mechanical Restraints from pick-up at VIDC and to [be] removed once detainee is secured in his seat on board'. The reason given for this was 'information received of the threats made by the detainee that he would disrupt the removal process by becoming physically disruptive and uncooperative towards his removal'. Around 20 minutes later, Serco sent a further email saying:
- [Redacted] advises the Case Manager made a verbal report and no incident report has been lodged yet on Portal. Can you please add the application of a face mask request to DIBP for the duration of the escort.
256. Based on these emails from Serco, a Detention Operations Officer of the department recommended the approval of the following levels of use of force:
- planned use of EEP in non-secure areas
  - planned use of mechanical restraints for escort to Sydney Airport and for the duration of the flight
  - face mask to be used for the duration of the escort.
257. The officer provided the following explanation:
- [Mr EJ] has become increasingly threatening and unco-operative with Case Resolution staff and has stated that he will do 'whatever it takes' to avoid being removed. He claims that he is skilled in martial arts and has made allusions that he will use violence against Serco officers ("They'll do what they have to do and I'll do what I have to do ...") or will otherwise cause a disruption in order to prevent him being removed from Australia.
258. The officer did not say that Mr EJ had made a threat to spit or bite anyone.
259. On 19 December 2014, the date scheduled for Mr EJ's removal, an officer of the Compliance Operations and Detention Division sent an email stating that 'Mechanical restraints and use of the surgical mask to prevent spitting or biting etc is approved'.
260. The updated EOO as it stood on the date scheduled for Mr EJ's departure (19 December 2014) relevantly provided:
- Detainee to be Mechanically Restrained prior to departure from VIDC. Mechanical Restraints to remain applied for duration of removal and be removed prior to detainee disembarking from aircraft in Beijing.

- Face Mask to be applied on detainee prior to departure from VIDC and only removed on board the aircraft should detainee be compliant, if not, face mask to remain on for duration of escort except when detainee has meals and refreshment and reapplied following the intake of meals and refreshment. Face Mask to be removed prior to detainee disembarking aircraft at Beijing.

261. The log prepared by Serco notes that Mr EJ was taken to the Airport directly from the Federal Court. The log records at 7.37pm:

CSO [redacted] advised [sic] detainee that a mask will be put on his mouth & he will be handcuffed according to the threats he's made that he will spit & bite & attack officers. Detainee denied that he made threats to spit & bite & he said that if his case manager made a claim that this is his threats then the case manager committed a crime & CSO's commit a crime again by putting cuffs & mask. T/L explained to him that this is the procedure required.

262. The denial by Mr EJ that he had made any threat to spit or bite, as recorded by Serco, is consistent with Mr EJ's account:

The 4 guards from Serco ... told me that "because I have threatened to spit & bite the security guards, they decided to not only handcuff me but also put a mask on my face". I got shocked because I have never said that. I questioned them who had make up [sic] these words. They said they had recorded it ... into writing by my case officer [name]. I challenged them that pls show me what [the case officer] had wrote down, & I would make a formal statement to police at the police station for [the officer's] wrongful accusation & perjury.

263. The log records that handcuffs and a spit hood were placed on Mr EJ at 7.55pm.

264. The attempt to deport Mr EJ on 19 December 2014 was not successful. According to a departmental incident report, 'as per instructions from the captain of the flight, detainee [Mr EJ] was escorted from the aircraft with mechanical restraints still applied on being disruptive prior to pushback'. According to the log prepared by Serco, the disturbance involved Mr EJ running up the aisle of the plane after using the toilet and calling out:

I am asylum seeker. They are forcing me to go back to China. They are not police, they are immigration. Look how they treat me, they want me to put mask on.

265. After the disturbance, some passengers remained standing in the aisle. According to the Serco log, the captain decided to return the aircraft to the gate because some passengers were not sitting down.

266. When the Commission first asked the department to comment on Mr EJ's claim that he was required to wear a face mask, the department said:

On 18 December 2014, Serco requested approvals for the use of Enhanced Escort Position and mechanical restraints in non-secure areas of the airport. Serco also requested use of a face mask on [Mr EJ] to be applied for the duration of the escort. These requests were made based on [Mr EJ's] Escort Security Risk Assessment and as necessary measures to mitigate the possibility of [Mr EJ] exhibiting non-compliant or inappropriate behaviour (based on previous verbal threats to spit at or bite the escort staff).



267. The Commission then sought copies of contemporaneous documents regarding Mr EJ's alleged threats to spit at or bite the escort staff, to use violence against Serco officers and to cause a disruption to prevent his removal. The most relevant record the department was able to provide was a Stakeholder Information Sheet dated 11 December 2014 from DIBP – Case management. The sheet noted:

[Mr EJ] was provided with notification of his removal from Australia on the 11/12/2014 and provided with the documentation. He was unwilling to sign the receipt of notification.

Whilst providing information about escorts he became agitated and raised his voice. He started to question about the travel document that was obtained for his removal. He **previously mentioned** that he will harm others or do anything in his power not to be removed from A/a.

CM warned him that DIBP does not take threats lightly and **if required** he will be handcuffed and/or masked for the protection of other staff or members of the public whilst on the flight.

(emphasis added)

268. The department was unable to provide any contemporaneous record, such as an incident report, of the alleged threat of harm referred to in this Stakeholder Information Sheet. The department has not provided any record which indicates that Mr EJ has ever made a threat to bite or spit at any person. As the records of both Serco and Mr EJ show, Mr EJ specifically denied ever making such a threat when Serco told him that they would be putting a face mask on him.

269. On the basis of the material provided by the department and Mr EJ, I am not satisfied that Mr EJ made any threat, whether direct or indirect, to bite or spit at escort staff. I find that the decision to authorise the use of a face mask on Mr EJ for his escort to the flight and, if necessary, for the duration of the flight from Australia to China, was disproportionate to any risk faced.

270. I find that the use of a face mask on Mr EJ was inconsistent with and contrary to his right under article 10 of the ICCPR to be treated with humanity and with respect for his inherent dignity.

## 10 Use of force within detention centres

271. The Commission has received a number of complaints about use of force within immigration detention centres.

272. I consider complaints by four detainees in the case studies that follow. In summary:

- (a) In the case of Mr FE, I find that force was used on him in a situation where it was unnecessary, as he had already been contained inside an accommodation block and officers opened the door and entered the room in order to use force on him. Further, I am concerned about the application of downward force to Mr FE's head while it was in contact with the concrete floor. I find that this caused his implanted tooth to be dislodged. I find that these acts were inconsistent with and contrary to Mr FE's rights under article 10 of the ICCPR to be treated with humanity and with respect for his inherent dignity.

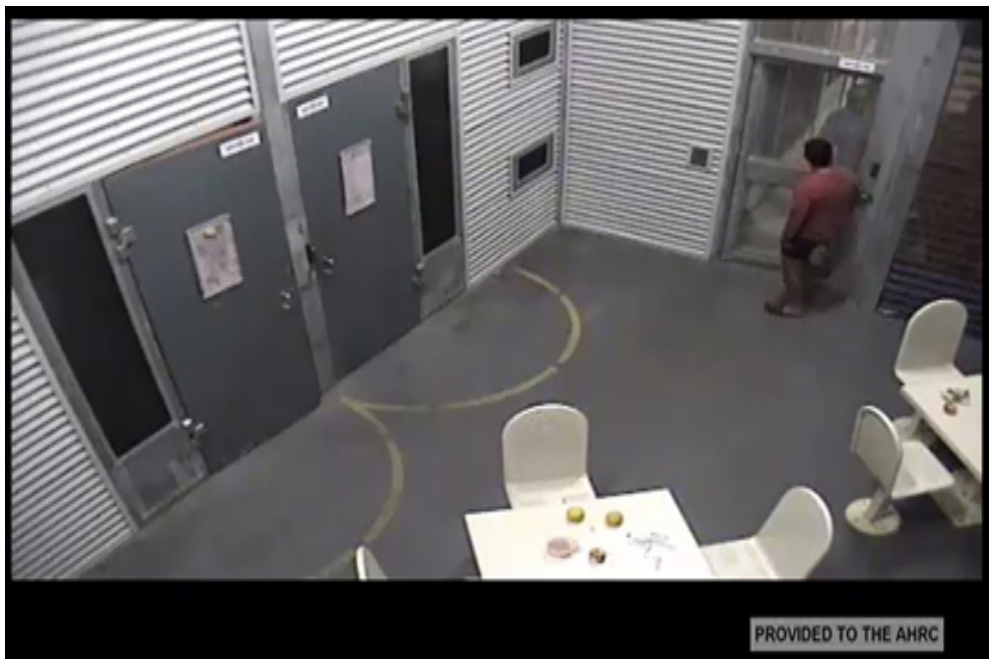
- (b) In the case of Mr GH, I find that the use of force to restrain him and escort him to an interview room was proportionate to the need to maintain good order at Maribyrnong IDC. The use of force followed allegedly disruptive behaviour by Mr GH and a failure by him to voluntarily accompany officers to the interview room.
- (c) In the case of Mr HF, I find that the actions of Serco officers during an interview with Mr HF about the need for him to move rooms caused the situation to escalate into an avoidable use of force. I find that force was not used as a last resort and that other communication, negotiation and conflict de-escalation strategies could and should have been attempted. The failure to use force as a last resort was inconsistent with and contrary to Mr HF's right under article 10 of the ICCPR to be treated with humanity and with respect for his inherent dignity.
- (d) In the case of Mr JB, I find that the conduct of Serco officers in conducting a pat search of him was not inconsistent with or contrary to his human rights.

## 10.1 Case study: Mr FE

### (a) Incident

- 273. Mr FE complains about an incident in April 2015 when Serco officers used force against him while he was detained in Christmas Island IDC. The use of force on Mr FE was captured by a CCTV camera. The department provided the Commission with a copy of the CCTV footage.
- 274. The incident occurred in the evening after dinner. Mr FE went to IHMS dispensary to receive medication. He was accompanied by a Serco Emergency Response Team (ERT) section leader and four other ERT officers. After collecting his medication, the officers accompanied him back to his accommodation block.
- 275. The CCTV footage provided is from inside the accommodation block. There is a mesh fence alongside the door and it is not possible to see clearly what happened outside of the block. Mr FE and the ERT section leader give different accounts of what occurred before Mr FE entered the accommodation block.
- 276. According to Mr FE, one of the officers offered to let him in. He said that a second officer replied 'Nah mate, I'll let him in' and as the second officer was trying to open the door, he elbowed Mr FE in the chest. Mr FE says that he asked the second officer why he did that. He said that the second officer turned to the first officer and said: 'Did you see me elbow him?' and the first officer replied 'No' with a grin. Mr FE says that he then said 'Can you please open the door' and the second officer said 'Don't fucking tell me what to do'. Mr FE says that the second officer opened the door but only opened it just enough for him to squeeze through. He says that after he was in the accommodation compound and the officers were closing the door he gave the door a kick.

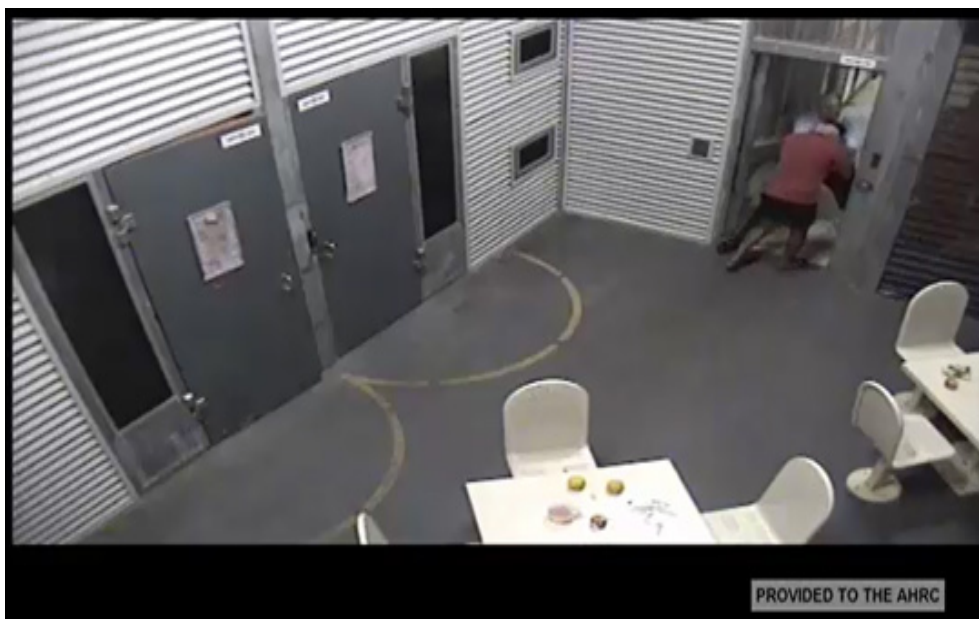
277. According to the ERT section leader, when Mr FE was outside the door 'he was asked politely to move aside so I could access the swipe to unlock the block door' and then became 'belligerent and argumentative'. The section leader said that Mr FE's 'body language was very threatening and as he passed by me he stared at my face very intently'. The ERT section leader said that after Mr FE entered the accommodation block he 'turned and suddenly shouted "Come on man, what's your fucking problem?" and then kicked the door and screamed "Open this fucking door"'.
278. The CCTV footage does not have any sound. It shows that when Mr FE enters the accommodation block, he is wearing slippers. He is moving slowly and does not appear agitated. He is carrying a white packet in his right hand which I infer was his medication. As the ERT officer is closing the door, he kicks the base of the door lightly with the toe of his foot. At this stage the door is almost closed. Mr FE's arms are hanging loosely by his sides. There is no visible sign that he is screaming.



Mr FE kicking the door after entering the accommodation block (1 min 22 secs).

279. After the kick to the door, the ERT section leader opens the door again and braces it open with his foot. Mr FE takes a step towards him, but does not cross the threshold of the doorway. He gestures towards one of the officers with his right hand while holding the white packet. It appears that he says something but it is not possible to determine what is said as Mr FE is facing away from the camera and there is no sound on the CCTV.

280. The ERT section leader alleges in his Use of Force Report that Mr FE pointed at him and said 'I will fucking kill you' and that Mr FE 'stepped towards me in a manner I deemed to be threatening'. Each of the accompanying officers under his leadership give slightly different accounts of this alleged threat. A second ERT officer alleges that Mr FE said 'Fuck you, I will kill you'. A third ERT officer alleges that Mr FE said 'I'm going to kill you'. A fourth ERT officer alleges that Mr FE said 'I'm going to fucking kill you'. A fifth ERT officer alleges that Mr FE said 'I am going to kill you'. The ERT section leader says that he felt 'quite concerned' and that he 'initiated a use of force in order to prevent assault to myself and my fellow officers'.
281. Mr FE says that he was complaining that the officers had not opened the door properly so that he could enter the accommodation block. The lack of sound on the CCTV means that it is not possible to make any conclusions about whether or not there was a threat made in one of the various ways alleged by the ERT officers or at all.
282. The CCTV footage shows that there was no pause in the movements of the ERT section leader between opening the door, bracing it with his foot and grappling with Mr FE. Prior to opening the door there was no physical risk to either the ERT section leader or the other four members of the emergency response team accompanying him. I find that the section leader opened the door with the intention of using force on Mr FE.



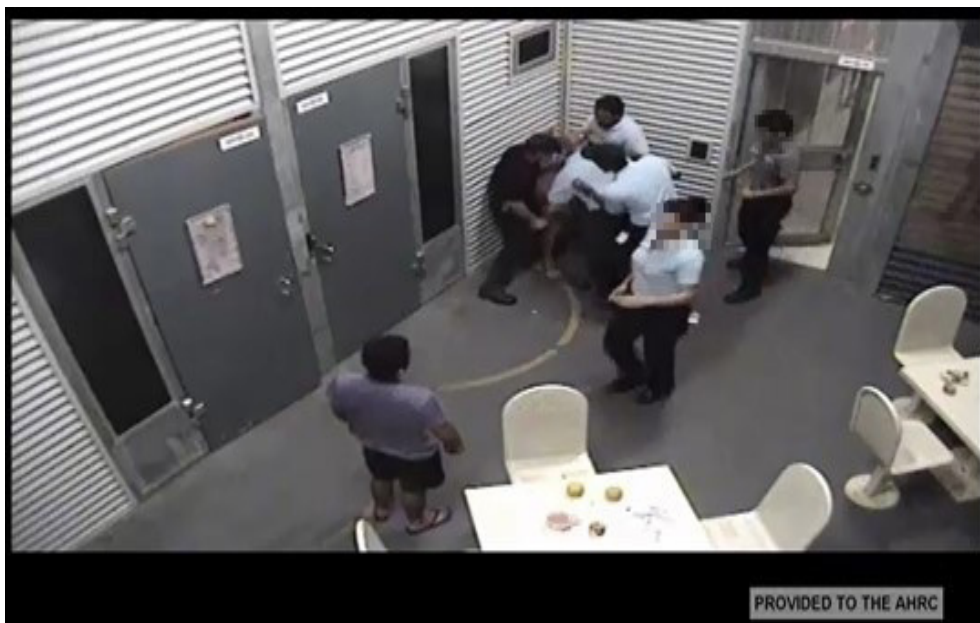
The ERT section leader steps towards Mr FE and grapples with his head, forcing it down (1 min 25 secs).

283. After initially grappling with Mr FE, the ERT section leader forces Mr FE backwards into the accommodation block. As he does so, Mr FE drops the packet he was carrying.



The ERT section leader continues to grapple with Mr FE, forcing him backwards into the accommodation block (1 min 25 secs).

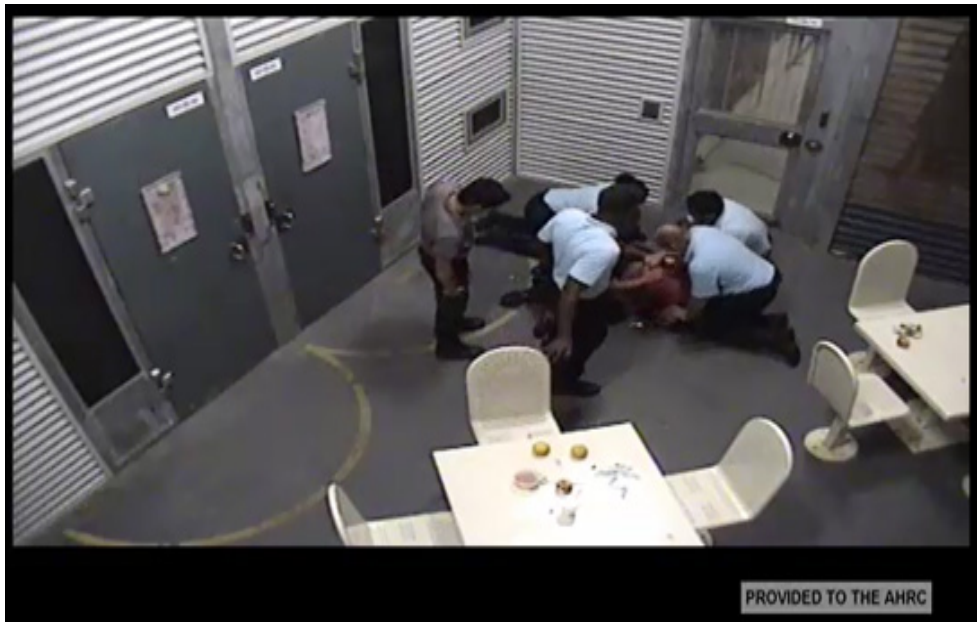
284. The other four ERT officers assist with grappling with Mr FE and bringing him to the ground. During the course of grappling with Mr FE, one of the officers swings a straight arm towards Mr FE's ribs. The quality of the video is low, but it appears that the officer may have used a closed fist. In a subsequent investigation report by Serco, this is described as the officer 'execut[ing] a thrusting motion with his right arm' that has 'the appearance of a punch'. However, based on a subsequent interview with the officer involved, the Serco investigation report concludes that the officer was merely attempting to gain control of Mr FE's wrist and apply a wrist-lock. It is difficult to see from the video where the officer makes contact because the view is obscured by the other officers. I am not able to be satisfied that a punch occurred. However, I am concerned that the action by the officer appeared to be a striking action rather than a grappling action.



Swinging arm by an ERT member in dark clothing (1 min 30 secs).

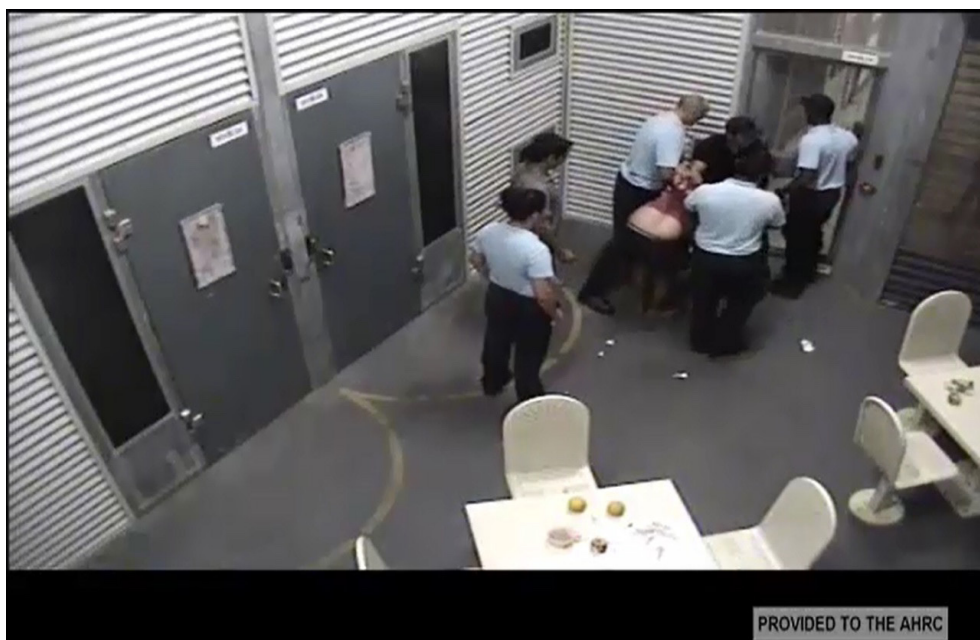
- 285. Four officers force Mr FE into the corner of the room and then bring him to the ground. He is placed face down with his hands behind his back. Two other officers join in grappling with Mr FE while he is on the ground.
- 286. While Mr FE is on the ground, his head is turned to the side and the left side of his face is in contact with the bare concrete floor. The ERT section leader is applying force to the side of his head to keep him down. Mr FE claims that the force used against him resulted in his left incisor being knocked loose. In a complaint to Serco after this incident, he said:

[M]y mouth was on the floor and he pushed my head and my teeth hit the floor. That's [the] way I loose[n] my teeth and after the[y] handcuff me.



ERT section leader with left hand applying downward force on Mr FE's head while on the floor (3 mins 42 secs).

287. After Mr FE was taken to the ground, the ERT section leader applies flexi-cuffs to his wrists to restrain his arms behind his back. The ERT section leader says that he did this because Mr FE 'spat blood at us'. A second ERT officer responsible for securing Mr FE's legs also reported that Mr FE was spitting blood. These reports are consistent with Mr FE's claim of an injury to his mouth as a result of the use of force incident. However, there is no sign of blood on the floor during the course of the CCTV footage.
288. Once Mr FE is restrained, he is rolled onto his side and then lifted onto his feet. After he is on his feet, with his hands cuffed behind his back, two Serco officers forcefully raise his hands which has the effect of forcing his head down. This appears to be done with more force than necessary. A third Serco officer takes control of his head and holds it while Mr FE is doubled over in a crouch position. This is the position that he is in as he is led out of the accommodation block. The white packet that Mr FE dropped is still on the floor.



Mr FE is led out of the accommodation block (4 mins 12 secs).

289. The Commission does not have any CCTV footage after Mr FE left the accommodation block. In his complaint to the Commission, he said that 'as they were taking me away I was constantly bleeding from the mouth'. He said that:

[T]hey got me on my knees in the hallway ... . At this time I was already on my knees and ... was spitting blood out to clear my mouth. The officer ... kneeed me in my lower back and said to me "don't spit it out, hold it in your mouth".

290. I am satisfied that Mr FE's mouth was injured as a result of the use of force incident and that he was spitting out blood. I am not satisfied that Mr FE was spitting blood before being handcuffed or that this was the reason for him being handcuffed. Rather, I find that Mr FE was spitting blood after he had already been handcuffed and had been escorted from the room.

291. The department says that following the incident Mr FE was segregated in an isolation unit (the North West Point Support Unit in Red Compound) for 23 hours. It says that this was for the purpose of maintaining the safety and good order of the centre.

292. Serco conducted an internal investigation of this incident and three other use of force incidents that occurred over a three week period at Christmas Island IDC in April and May 2015. In relation to this incident and another incident (details of which were not provided to the Commission), the investigation concluded that the particular ERT section leader involved (the same person in each case) 'made poor operational decisions which acted as a catalyst to the Use of Force'. In this incident, the poor operational decision identified by Serco was reopening the door after Mr FE was already safely in the accommodation block. Serco said:



CSO ... showed poor practice by re-opening the Compound door which only destabilised a contained situation resulting in an avoidable Use of Force.

It also said:

Serco's Use of Force protocol requires de-escalation where possible. It is the view of the investigator that there is no discernible attempt to de-escalate the situation.

293. Serco recommended that the CSO be counselled in relation to his poor practice and that he not be utilised as an ERT Team Leader until further assessed by the National ERT Manager. It also recommended that Christmas Island IDC managers and staff undergo refresher training in de-escalation techniques.
294. Despite these findings and recommendations, the Serco Centre Manager for the North West Point IDC wrote to Mr FE the day after the conclusion of the internal investigation saying that his complaint had been reviewed and that 'there has been found to be no breach in the application of the Use of Force policy'. This was not the conclusion of the internal investigation.

#### **(b) Medical treatment**

295. Mr FE was reviewed by IHMS in a medical clinic on 23, 24 and 27 April 2015. Despite a request from the Commission and the written consent of Mr FE, the department declined to voluntarily provide the Commission with copies of Mr FE's relevant medical records and instead provided its own summary of those records. The department did not provide any reasons for failing to provide the requested records.
296. The department says that an IHMS GP observed on 27 April 2015 that Mr FE's left incisor tooth was loose. The department says that on 8 May 2015, at a further IHMS review, a GP noted that Mr FE had lost his left incisor and Mr FE reported that the tooth had fallen out two days previously. The department says that, according to its records, Mr FE had undergone a dental procedure to this tooth in September 2014 in which his native tooth was extracted and an implant inserted. It appears from the department's submissions that the tooth that was dislodged was his implant.
297. The department says that Mr FE underwent a dental procedure on 12 May 2015 to remove a small amount of the remaining tooth. It says that in June 2015 he was fitted with a partial denture plate for his missing tooth.

#### **(c) AFP investigation**

298. At the request of Mr FE, the incident was referred to the Australian Federal Police (AFP) in May 2015. On 22 June 2015, the AFP wrote to the Security Liaison Officer at Christmas Island IDC and said that there was insufficient evidence to proceed to a prosecution for common assault or assault causing bodily harm. The AFP said that its assessment was based on:
- the lack of a statement of complaint from [Mr FE];
  - inability to show conclusively the tooth was damaged as a result of the incident on 23 April 2015; and
  - the assault was lawful, that means it was authorised, justified or excused by law.

299. It is unclear why the AFP were unable to obtain a statement from Mr FE. It appears that the conclusion that the assault was lawful is related to the question of whether or not there was sufficient evidence to prove that excessive force was used.
300. In order for a prosecution to be successful, there must be sufficient evidence to prove each of the elements of a relevant offence beyond reasonable doubt. The fact that the AFP concluded that a prosecution was unlikely to be successful does not preclude the Commission making an assessment of whether it is satisfied that there was a relevant act or practice that was inconsistent with or contrary to Mr FE's human rights.

**(d) Assessment**

301. In response to my preliminary views in this matter, the department submitted that the use of force on Mr FE was necessary and was in line with use of force policy. I am unable to accept those submissions.
302. I find that the decision to use force in this case was unnecessary, excessive and contrary to both Serco's Operational Safety Manual and the department's Detention Services Manual.
303. Clause 2.4.1 of Serco's Operational Safety Manual provides that an unplanned use of force is required where there is an immediate threat of harm to any person, an immediate risk of escape or immediate destruction of property. None of these conditions were present in this instance. As Serco subsequently found, there was no immediate threat of harm to any person. It was only by re-opening the compound door that a contained situation was allowed to escalate. There was no risk of escape and there was no damage to property. It appears from Serco's post-incident investigation that this was not the only time that the relevant ERT section leader had shown poor operational decisions which acted as a catalyst for a use of force.
304. The department's Detention Services Manual provides that officers may use an appropriate level of reasonable force in order to protect themselves and others, when safety issues arise in conjunction with the performance of their duties. Reasonable force is defined as follows:

Reasonable force is the minimum amount of force, and no more, necessary to achieve legislative outcomes and/or ensure the safety of all detainees, staff and property. The use of force is considered to be reasonable if it is objectively justifiable and proportionate to the risk faced. Action that may be used to control a situation will range from non-contact options (for example, physical presence alone), to options involving physical contact.

305. As noted above, it was not necessary for force to be used in this situation at all. Further, at least two aspects of the use of force were excessive, even if force had been necessary. These aspects are:
- the application of downward force to Mr FE's head while it was in contact with the concrete floor
  - the forcing of Mr FE's hands upwards with more force than necessary after he had been handcuffed behind his back which had the effect of forcing his head down.

306. I find that the application of downward force to Mr FE's head caused his implanted tooth to be dislodged. The following material supports this finding:
- (a) the claims made by Mr FE in his complaint to the Commission
  - (b) the CCTV footage showing the left side of his face making contact with the floor and the application of force by the ERT section lead to keep his head in that position
  - (c) the contemporaneous records of the ERT section lead and another ERT officer that Mr FE was spitting blood
  - (d) the department's description of Mr FE's medical records which show that after the use of force his tooth was loose and that he subsequently lost it.
307. I find that the decision by the ERT section leader to use force on Mr FE and the application of downward force to Mr FE's head while it was in contact with the concrete floor were each acts that were contrary to and inconsistent with Mr FE's right under article 10 of the ICCPR to be treated with humanity and with respect for his inherent dignity. In particular, these acts were inconsistent with rule 54(1) of the Standard Minimum Rules which requires that force should only be used in self-defence, in cases of attempted escape, or in response to active or passive physical resistance to a lawful order and that when force is used it must be no more than is strictly necessary.

## 10.2 Case study: Mr GH

308. Mr GH complains about an incident in August 2015 when Serco officers used force against him while he was detained in Maribyrnong IDC.
309. The use of force on Mr GH was captured by a CCTV camera. The department provided the Commission with a copy of the CCTV footage. Some parts of the incident leading up to the use of force were not captured by the camera.
310. According to contemporaneous reports by Serco, Mr GH refused to comply with a request that he enter a waiting room prior to collecting his medication. Instead, he reportedly insisted on waiting in a corridor area where another detainee was receiving his medication. In response to a request from staff to enter the waiting room, Mr GH reportedly 'began yelling profanities'. These events are not captured on CCTV.
311. The video of the incident commences when Mr GH approaches a dispensing window to receive medication. Two officers are waiting next to him as he receives his medication. He turns to them and takes a couple of small steps as if to go around them (at 3 mins 8 secs on the video). One officer puts a hand on his arm and the other points down the corridor in the opposite direction. According to the Serco reports, the officers were asking Mr GH to go to an interview room to discuss the earlier incident in the waiting room. This is consistent with the video. The request seems to be repeated a number of times. The second officer points down the corridor five times in quick succession.

312. Mr GH takes a step forward as if to move between the officers. The officers step together and close the gap. According to the report of one Serco officer, Mr GH 'aggressively began to yell at me pointing his finger at my face and in my personal space'. There is no sound on the CCTV footage. Mr GH does not appear to be physically aggressive but he does appear to raise his finger and say something and then again attempts to walk in between the officers. At this point, the officers grappled with his arms and then forced him to the floor. One of the officers falls on top of Mr GH.
313. Mr GH complains that the officers 'pushed me down to the floor, hitting my neck with their knees violently bashing me'. There is no evidence of Mr GH being 'bashed'.
314. Both Serco and Mr GH agree that a call was made for further officers who arrived shortly. Mr GH struggled on the ground as the officers attempted to restrain him for around 3 minutes. Mr GH was handcuffed using mechanical restraints and taken to a room where he was spoken to by the Operations Manager.
315. This is an incident where a detainee was providing some physical resistance to a request by Serco officers that he attend an interview room to discuss allegedly disruptive behaviour. I consider that there may have been other options available to the officers to de-escalate the situation. Mr GH did not appear to want a physical confrontation. However, given the allegedly disruptive behaviour and failure of Mr GH to comply with a request that he cooperate with officers, I find that the use of force by the officers was proportionate to the need to maintain good order in the centre. I find that it was not inconsistent with or contrary to Mr GH's human rights.

### 10.3 Case study: Mr HF

316. Mr HF's visa was cancelled as a result of being convicted of a number of criminal offences including three counts of indecent assault and failing to comply with reporting obligations. He was detained at Maribyrnong IDC. At the time he was detained he had also been charged with offences relating to dangerous driving causing serious injury and failing to stop and assist after an accident.
317. Mr HF complains about an incident in October 2015 in which Serco officers used force to move him from one section of Maribyrnong IDC to another. Mr HF was initially detained in Zone E. He was told that he was going to be moved to Zone D. Maribyrnong IDC currently operates under a 'controlled movement' policy which prevents detainees from moving between different zones.<sup>77</sup> Mr HF objected to the proposed move because Zone E contains a dedicated prayer room but Zone D does not. Mr HF is a Sikh and says that he used the prayer room to pray three times a day.

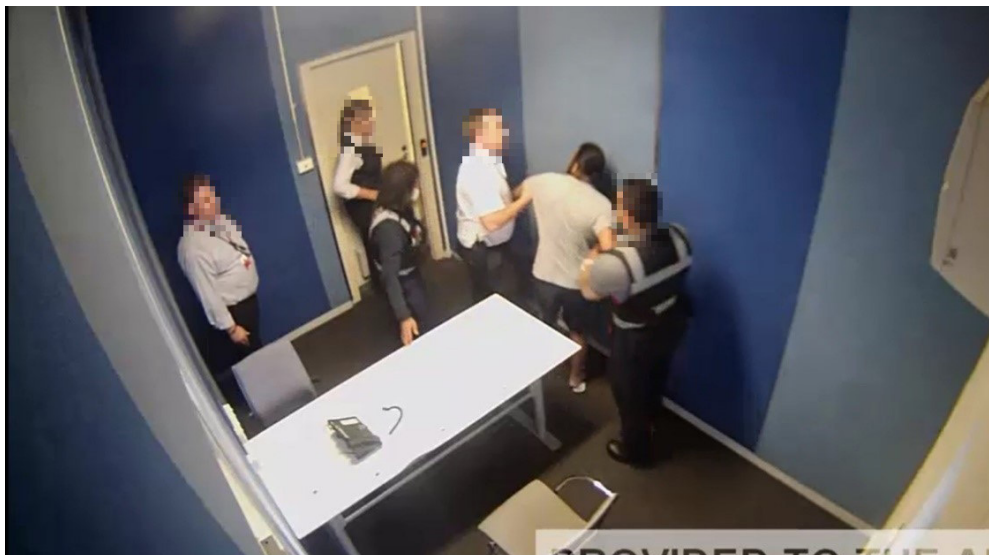
318. Mr HF was called to a meeting with Serco in an interview room. He claims that during the meeting he explained to Serco that he didn't want to move to Zone D because it would interfere with his religious practice, and that he stood up and said 'let me go back to my room and call me when the senior operation manager is available'. He claims that the officers then became aggressive and that force was used on him and he was handcuffed. He claims that in the attempt to handcuff him, one of the officers was 'pushing me very hard on my right shoulder even after I was screaming with pain'. He claims that he was put in a cell and had his mobile phone and religious necklace on a chain removed. He claims that he was not allowed to have his turban. He says that eventually he was moved to Zone D after 9 hours without food.
319. An incident report prepared by the Serco Facility Operations Manager says that he interviewed Mr HF at 10.50am and informed him that he would no longer be accommodated in Zone E and that his new accommodation would be in Zone D. He was 'offered multiple attempts to walk compliantly to Zone D to which [Mr HF] declined'. He was then informed that he would be escorted to Zone D. The report says: 'At this point [Mr HF] has become agitated and aggressive and attempted to leave the interview room'. Use of force 'escalated from EEP [Enhanced Escort Position] to control and restraint'. Serco officers applied mechanical restraints to Mr HF and he was escorted to a room in Zone C. This zone is typically used for single separation.<sup>78</sup>
320. A use of force report prepared by another Serco officer says that during the interview Mr HF 'was instructed by FOM [the Facility Operations Manager] to stay in interview room while we clear his current room and move his belongings to Zone D'. It was after this that he became agitated.
321. In response to a complaint by Mr HF to Serco, Serco conducted a review of the incident. In the response provided to Mr HF, Serco said that his placement in Zone E was deemed inappropriate due to his convictions and pending charges, that he was asked to move on 29 October 2015 and that he refused to comply. The response said force was used to escort Mr HF to 'restrictive detention' in Zone C because he failed to comply with a lawful and reasonable instruction. The response said that Mr HF was told that he could leave restrictive detention in Zone C at any time and move to Zone D to access meals and facilities there but that Mr HF failed to do so until approximately 8.00pm the same day.
322. In response to the complaint to the Commission, the department said that the decision to move Mr HF 'was based on a need to rebalance detainee numbers within the facility and to make space available for detainees who were due to arrive in the following days. Zone D was considered more appropriate for [Mr HF] due to his criminal history.' This response to the Commission said that Serco sought to engage with Mr HF on 28 October 2015 about his relocation and the concerns he had raised about access to the multi-faith room. The department said that Mr HF could use the Programs and Activities Hub to pray while he was accommodated in Zone D. The department said that Mr HF's phone was removed from him because it was a source of distraction and that his necklace was removed 'as it may have been used by him to self-harm (noting his escalated emotional state)'. The department says that these items were returned to Mr HF when he moved to Zone D later that evening.

323. In response to my preliminary view, the department said that negotiation and conflict de-escalation strategies were attempted and that minimal force was only used after several attempts had been made to encourage Mr HF to move voluntarily. The department said that the use of force was reasonable and proportionate in the circumstances.
324. The interview with Mr HF was captured on fixed CCTV camera in the interview room but there is no sound accompanying this video. There are four Serco officers in the room at the start of the interview. The Facility Operations Manager is sitting and facing Mr HF across a table. Two other Serco officers stand next to the door to the room which is ajar. One Serco Emergency Response Team officer stands behind Mr HF. That officer is wearing a body camera which shows video of the interview but no sound. For most of this video the body camera is positioned so that the face of the Facility Operations Manager cannot be seen. During one part of the interview, his face can be seen and he appears to give Mr HF a warning about the use of force. He appears to say words to the effect: 'Your choices now are that you decide that you're going to behave, or ...'. Shortly after this, a second ERT officer enters the interview room and the door is closed.
325. Three minutes into the interview, the Facility Operations Manager stands up and appears to wave to the ERT officer behind Mr HF to follow him out of the room (at 4 mins 21 secs on the CCTV video). The Facility Operations Manager appears to indicate to Mr HF to remain in the interview room. Mr HF then stands up and takes a couple of steps towards the door (at 4 mins 40 secs on the CCTV video). The ERT officer behind him places a hand on his arm and gestures back to Mr HF's chair, inviting him to sit back down. The Facility Operations Manager and a second ERT officer step in front of Mr HF blocking his path to the door. The Facility Operations Manager and two other officers then also gesture for Mr HF to sit down. The ERT officers appear calm and use reassuring open handed gestures to try to calm Mr HF down.
326. The Facility Operations Manager appears to tell Mr HF to 'sit down' several times. Mr HF takes a step backwards towards his chair. At one point, Mr HF appears to suggest that the Facility Operations Manager also sit down by pointing to his chair. At this point, about 25 seconds after Mr HF first stood up, the Facility Operations Manager appears to lose patience and grabs Mr HF under his left upper arm and leads him towards the door. At this point, the Facility Operations Manager has made a decision that at least some force will be used to move Mr HF.



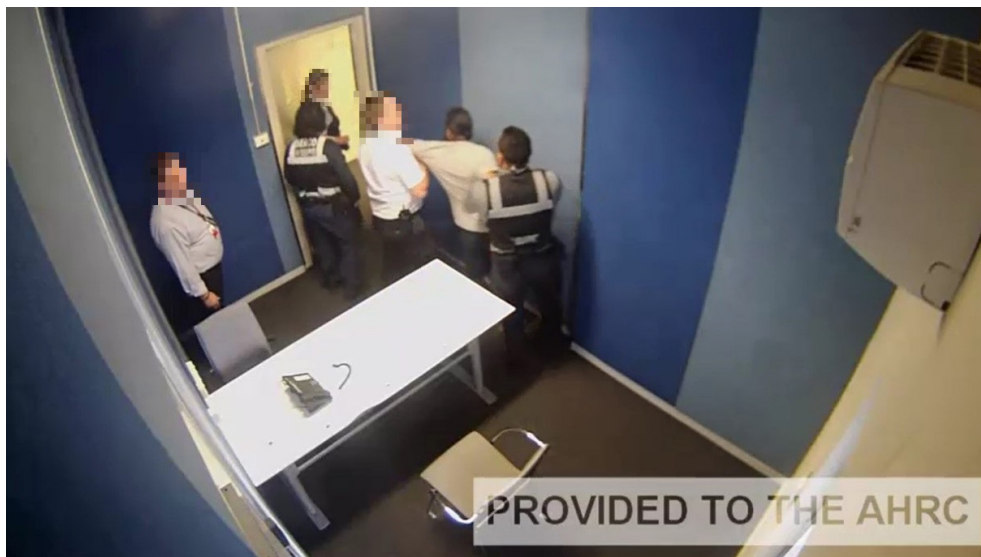
Facility Operations Manager initiates use of force (5 mins 5 secs).

327. The ERT officer behind Mr HF takes hold of his right upper arm. It appears that they intend to escort him out of the room that way.



Mr HF is led towards the door (5 mins 7 secs).

328. Mr HF resists being taken through the doorway.



Mr HF provides some resistance (5 mins 8 secs).

329. This resistance is firmly met and the use of force escalates.



The use of force escalates (5 mins 10 secs).



330. Mr HF is forced up against the wall first by the Facility Operations Manager and immediately after by the other ERT officer escorting him. The second ERT officer intervenes and takes control of Mr HF's head. Another Serco officer produces handcuffs. Mr HF resists having handcuffs applied. A third ERT officer enters the room and assists in grappling with Mr HF, relieving the Facility Operations Manager. The Facility Operations Manager then crouches in front of Mr HF and appears to grapple with his leg. At this point, the four officers succeed in bringing Mr HF onto the ground because he is resisting strongly (at 6 mins 20 secs on the CCTV video). Mechanical handcuffs are then applied behind his back, the officers stand Mr HF up and then sit him in a chair. This use of force lasts for about two and a half minutes.
331. Once Mr HF is handcuffed and sitting in the chair, he stops struggling. Two ERT officers seek to calm him down by putting an open hand on his shoulders and by talking to him. They do not appear to use any more force than is necessary. They check to make sure that the handcuffs are not too tight.
332. Mr HF is then escorted to a room in Zone C. This is filmed on a body camera of two of the ERT officers and the video (unlike the earlier videos) has sound. The walk along the corridors takes about a minute. Mr HF is compliant during this escort. The officers do not attempt to drag him or force his arms over his head. Once in Zone C, he complains to the officers about the decision to use force against him. One of the ERT officers conducts a pat search. Mr HF appears to make a threat of self-harm. Mr HF's religious necklace and phone are taken from him. He is told that the items will be held securely and returned to him. He is required to kneel in a corner of the room while the handcuffs are removed from his wrists. After the handcuffs are removed, Mr HF holds his right shoulder and tells the officers he has a pain in his back. Serco says that medical officers would come to check him.
333. Medical records produced by the department show that Mr HF was seen by a nurse from IHMS while he was in Zone C. He complained of 'moderate' pain in his right shoulder and was given 1g of paracetamol. The nurse reported that Mr HF appeared to be able to move his shoulder with minimal effort and that although he sounded angry and anxious he did not seem to be stressed by pain.
334. Mr HF claims that he has had ongoing problems with his shoulder that has affected his ability to work. He also claims that he has been taking anti-depressants since the incident. Mr HF suggested that the Commission seek further medical records but, despite several requests, he did not provide the Commission with the written authority necessary to obtain this information. On the basis of the medial records available to me from his time in immigration detention, I am not able to conclude that Mr HF sustained a serious or ongoing injury as a result of this use of force.
335. My findings in relation to this incident are as follows:
- (a) Contrary to the Serco incident report, the video footage does not suggest that Mr HF became 'aggressive' or attempted to leave the interview room. Rather, it appears that, after a discussion with Mr HF lasting three minutes, the Facility Operations Manager did not want to continue to negotiate with him and decided to use at least some force to escort him to Zone D. Mr HF was already in an agitated state as a result of the interview. It may be that he became more agitated when he was told (as it appears) that his belongings were being moved to Zone D.

- (b) After the decision was made to escort him using holds under his upper arms, he resisted and the use of force quickly escalated. This was a predictable result of the initial decision to use force.
- (c) Once the process of using force had commenced, and Mr HF had resisted, it does not appear that more force was used than was necessary to restrain Mr HF. I consider that the ERT officers acted appropriately. After being restrained, Mr HF was compliant with the request to move to Zone C.
- (d) In the circumstances, I am not satisfied that force was used as a measure of last resort as required by Serco's contract with the department, the department's Detention Services Manual and Serco's Operational Safety Manual. Serco's Operational Safety Manual provides that:

Communication, negotiation and conflict de-escalation are the foundation stones of the Operational Safety Continuum, and are the primary skills employed in the management of any incident. Use of force is a last resort.

- (e) Here, Serco had identified an operational need to move Mr HF in anticipation of new detainees arriving 'in the following days', however it could not be said that the need to move Mr HF was urgent. In this case, other communication, negotiation and conflict de-escalation strategies could and should have been attempted.
  - (f) The failure to use force as a last resort was inconsistent with or contrary to Mr HF's right under article 10 of the ICCPR to be treated with humanity and with respect for his inherent dignity.
336. While the facilities in Zone E included a dedicated prayer room, it appears that there was an activities room in Zone D which could be used for prayer. The department and Serco need to have flexibility in making decisions about placement of detainees in different zones. Similarly, I am satisfied that the decision to require Mr HF to temporarily remove his religious necklace was made to ensure his safety. In each case, I am not satisfied that there was an arbitrary interference with Mr HF's religion. Nevertheless, the unequal distribution of facilities between zones is an issue highlighted by the Commission in its recent review of Maribyrnong IDC.<sup>79</sup>
337. Mr HF also complains about a separate incident later the same day once he had moved to a new room in Zone D. He claims that around 8.30pm he asked a Serco officer to speak with the other detainees in his room about turning off the air conditioner. He claims that the officer replied that he should deal with that on his own. He claims that he turned the air conditioner off by standing on a table and pressing the button hard. He claims that the Serco officer then became aggressive, saying that he was damaging property and started kicking him, twisted his arm, threw him down from the table and kicked him again.
338. An incident report by the Facility Operations Manager says that Mr HF 'without warning then climbed on the table and punched the air con unit 2 times causing the exterior of the unit to become dented. ERT Officer ... verbally told him to stop and then when he didn't ERT Officer ... took control of his arms by holding them down and assisted [Mr HF] from the table for his own safety. ... [Mr HF] soon calmed down and the hold placed on him was released'.

339. A use of force report by the relevant officer said: '[Mr HF] ... jump[ed] on the table and hit twice the air-conditioner. I ... said "please stop" to the detainee but he was abusive and aggressive, so I jump[ed] on the table to calm him down and remove him from the table. I try to calm him down by controlling his lower arms and guiding down [off] the table. He resisted by attempt[ing] to break my holds by throwing his arms up, but I still managed to maintain my holds until such time [as] he was calming down and I was able to remove him from the table.'
340. The Commission has not reviewed any video footage of the incident. Based on the information available to me, I am not satisfied that the ERT officer became aggressive or kicked Mr HF. I am not satisfied that the conduct by the ERT officer was inconsistent with or contrary to Mr HF's human rights.

## 10.4 Case study: Mr JB

341. Mr JB is a Sri Lankan citizen who came to Australia in 2007 as a student. He overstayed his visa and was detained in 2014. He subsequently made an application for a protection visa.
342. Mr JB complains to the Commission about an incident in December 2015 when his room was searched. He says that during the search 'one of the officers grabbed me on the testicles quite hard'. He claims that in Sri Lanka he had been the victim of a violent sexual assault and that the conduct he alleges during his room search made him feel violated again.
343. Mr JB made a written complaint to Serco the day that the incident occurred. In that complaint, he said that Serco staff were 'very aggressive' towards him and that during the search one of the staff members 'touched my testicles and my dick too'. Serco reviewed a video recording of the incident and concluded that the officers acted in an appropriate manner and followed the correct pat search procedure. Mr JB was unsatisfied with the investigation of his complaint by Serco and made a further complaint to Serco in which he said that he had been 'abused sexually'. In response to the second complaint, Serco said that '[a]s the officers believed you to have a lighter on your person a more thorough pat search was conducted at the time of your room search'.
344. The department says that the search was conducted by Serco's Emergency Response Team as part of a targeted room search which is a normal operational requirement when there is a suspicion that contraband items may be held by a detainee.
345. The department says that the policy for conducting pat searches is contained in the Searching and Fabric Checks procedure which says:

### 4.3.1 Searching of Detainee Accommodation

For searches of accommodation to be conducted appropriately there must be a minimum of two staff, with at least one of the same sex as the Detainee. Their roles will be to:

- conduct a pat down search of the Detainee whose room is being searched, subject to clause 5.2 below, prior to the accommodation search (must be by the staff member of the same sex)

- digitally record the search (including the pat down)
- conduct the search
- complete the Search Form

346. The search of Mr JB's room and his pat down was filmed on a hand held camera. The Commission has viewed a recording of these events. At the start of the recording, the four male officers conducting the search are each introduced and their identification is shown. One officer uses a wand to scan Mr JB without touching him. This process takes less than a minute. Another officer then conducts a pat down search. This process takes around 30 seconds. Mr JB is asked to place his hands against the outside wall of his room and stand with his feet apart. During pat down, the officer places his hand between Mr JB's legs twice near the groin area. Mr JB flinches slightly on the first occasion. On the second occasion, the officer's hand moves quickly from the front of the groin to the back. No excessive force is applied. It appears possible that the officer may have made contact with Mr JB's testicles through the fabric of his pants but there is nothing to indicate that Mr JB's testicles were squeezed. All of the officers behave in a calm and respectful way.
347. Based on a review of the video, I am not satisfied that Mr JB's allegations that the Serco officers behaved in a 'very aggressive' manner or that they squeezed his testicles can be established. I find that the conduct by the Serco officers was not inconsistent with or contrary to Mr JB's human rights.

## 11 Wickham Point extraction

348. On 18 April 2015, the department conducted a major operation at Wickham Point immigration detention facility to remove 19 detainees and transfer them to immigration detention facilities in Melbourne. A number of the people removed made complaints to the Commission about the use of force during the operation.
349. The extraction followed a week during which there had been a number of major disturbances at Wickham Point. On 12 April 2015, a detainee engaged in a rooftop protest. This protest ended in the early hours of 13 April 2015 when the detainee voluntarily climbed down.
350. On 15 April 2015, according to a Serco report, detainees in the Sand compound became disruptive after two family groups were taken to another compound in preparation to remove them to Nauru. The detainees allegedly 'kicked open gates and climbed internal fences in order to gain access to movement areas in order to find the families'. The Northern Territory Police were called to restore order. Serco described the detainees involved as a group of 26 low to medium risk placement Iranian detainees who were subject to transfer to regional processing countries.
351. On 16 April 2015, some detainees allegedly carried out further protest action. According to the Serco report, two detainees climbed onto the Sand Compound roof before climbing down shortly thereafter. Other detainees allegedly threw furniture into the courtyard. One detainee allegedly assaulted a Serco officer and was removed from Sand compound. Approximately 40 detainees were said to have protested this action and demanded the return of the detainee. The Northern Territory Police were again called and engaged with the detainees.

352. On 17 April 2015, the department informed Serco that seven people identified as 'the main instigators' and their families were to be removed from Wickham Point. The planning for the extraction described the mission as being to 'extract and relocate identified detainees of interest who have been inciting and instigating non-compliance in order to restore and sustain community standards at WPIDF'.
353. The extraction operation commenced at approximately 5.30am on 18 April 2015. 19 detainees were removed from Wickham Point. 11 or 12 were taken to the now decommissioned Bladin APOD site. 7 or 8 were taken to the Darwin police watch-house. The following numbers of officers were involved in the extraction operation:
- more than 20 emergency response team (ERT) members (Serco officer reports say that there were 21 ERT officers, CCTV footage from the incident shows 23 officers in body armour exiting through the Sally Port at the end of the extraction)
  - approximately 30 Serco officers (CCTV footage of entry through Sally Port suggests 31)
  - 34 or 35 police officers from the Northern Territory police service supported the operation including mounted, canine (with two police dogs), public order management and command capabilities (according to Serco's post incident review).
354. The ERT officers are wearing body armour and helmets. Eleven of them carry plastic shields: one small round one and ten large shields of almost body height.
355. For each family group to be extracted, a large group of officers would first station themselves outside of the door to the family's room. ERT officers with shields were positioned across the corridor on one side of the door, while other officers opened the door behind them and entered the room.



ERT officers positioned to block corridor.

356. Each family member was extracted one at a time and led by two officers, one on each arm, through the corridors to a muster area. Most detainees were led away initially by ERT officers in riot gear, and then handed on to other Serco officers. The men were typically restrained with plastic flexi-cuffs in the front of their body, including two men in wheelchairs. Once in the muster area in the Sally Port, the men were required to wait either in plastic chairs or, in two cases, in wheelchairs, while still restrained with flexi-cuffs. They waited for approximately an hour before being put into vans for transfer to the Darwin police watch-house. The women and children were escorted straight to a larger bus, as was Ms LC's husband and their baby. After the women and children were removed, ERT officers replaced the flexi-cuffs worn by the remaining six male detainees with mechanical restraints (including for the two men in wheelchairs). Police officers then escorted each of the remaining detainees out of the muster area one by one and into the back of two waiting wagons. The front cab of the wagons was marked 'Police' and the separate compartment at the back was marked 'Metropolitan Patrol Group'. The men were patted down before being put into the wagon. The wagons had cage doors at the back and were padlocked once the men were inside. Just after dawn, the wagons left the Sally Port.
357. The department reports that the operation concluded at approximately 6.40am.
358. Serco prepared a six page Operational Concept which was provided to the department at 5.00pm on 17 April 2015, approximately 12 hours prior to the extraction. It also provided the department with a five page tactical plan. The operational concept listed seven people who were identified as 'agitators and spokespersons'. Three 'spokespersons' were identified as 'Priority 1' for extraction, while the remaining four 'agitators' were identified as 'Priority 2'. Those seven people along with their family members comprised the 19 people to be removed from the centre. For each of the seven people identified, Serco set out details of their name, ID number, risk rating, 'activity' (ie a spokesperson or an agitator), the compound and room they were accommodated in, gender and priority for extraction.
359. The Operational Concept did not include details of the family members of the seven identified people. It contained as an assumption that 'pre-approval of use of force and restraints is provided prior to the commencement of the operation'. However, it did not set out details of which people were proposed to be restrained. The seven people named in the document? Those people and any of their family members? Any other people that Serco considered should be restrained as part of the same operation? Presumably approval was not being sought to use force or restraints in a way that was inconsistent with Serco's contractual obligations, the department's Detention Services Manual or Serco's Operational Safety Manual. The Operational Concept document did not contain any individualised assessment of whether any of the 19 people to be extracted had particular vulnerabilities that meant that the use of restraints would not be appropriate. Nor was there any consideration of the ages or the security risk ratings of family members of the seven identified detainees.
360. After provision of the Operational Concept to the department at 5.00pm on 17 April 2015, approval for the use of force was sought in the following way:
- At 9.02pm AEST on 17 April 2015 the General Manager, North of Serco sent an email to an unidentified officer of the department saying: 'Hi ..., I would like to request approval for use of force and mechanical restraints for the extraction operation being conducted on Saturday 18 April 2015'.

- At 9.07pm AEST on 17 April 2015 the departmental officer responds by email saying: 'Hi ..., Approval for reasonable use of force and mechanical restraints is approved as required for the Saturday morning demonstration'.

361. The nature of this generalised approval suggests that there was no individual assessment about the use of restraints. No documents have been produced suggesting that there was any case by case assessment of whether each person to be extracted should be restrained or whether the use of restraints on that person was appropriate.
362. Although the tactical plan indicated that interpreters would be embedded with the ERT teams, the department later confirmed that interpreters were not used during the extraction. Interpreters were available at Darwin police watch-house.
363. The Commission has received individual complaints from families comprising 13 of the 19 people who were removed from Wickham Point during the extraction on 18 April 2015. Their complaints about the use of force during the extraction are considered in the case studies below.

## 11.1 Case study: Mr KE and Mrs KF

364. Mr KE, his wife Mrs KF and their three children were removed from Wickham Point as part of the extraction on 18 April 2015. They are from Iran and had arrived in Australia by boat as asylum seekers in August 2013. Mr KE was identified by Serco as an 'instigator' of some of the protest action. He denies that he was involved in any disturbances. A security risk assessment conducted by Serco indicated that prior to April 2015 Mr KE had only been involved in one incident of aggressive or abusive behaviour since he was detained 20 months previously and that his risk rating was 'low'.
365. The family made complaints about the use of force on them and the impact of the operation on their right to privacy. I deal with each of these issues in turn.

### (a) Use of force

366. Mrs KF said that she was in bed when many officers entered her room early in the morning. She was surprised and shocked. She said that two officers held her by each hand and took her out of bed. She said that she was the first person in her family to be led away. She shared a room with her husband and their youngest son while their other two children were in the room next door. She says that officers led her to the property area, with one officer holding each of her arms, and told her that they would bring her husband and their children. CCTV indicates that Mrs KF was initially escorted by one ERT officer in riot gear.



Mrs KF is escorted by an ERT officer.

367. She said that after she arrived in the property area, one of the officers brought in her youngest son, KI, who was then 9 years old. She said that KI was scared and shaking and she could see that he had wet himself. The department says that the ERT officer involved in this transfer confirmed that Master KI was frightened when the officer entered the room, but said that the officer was not aware that the boy had wet himself. The department says that there is 'no evidence to substantiate this allegation'. The department says that Master KI was separated from his mother for approximately five minutes before being reunited on the bus taking them to Bladin.
368. I find that the force used on Mrs KF was proportionate. I do not consider that it was inconsistent with or contrary to her human rights. I acknowledge that the presence of dozens of Serco officers, including heavily armoured ERT officers, would have created an environment in which a nine year old boy may reasonably have been distressed and fearful. As I discuss in more detail below, for an extraction operation that involved young children there are real questions about whether this kind of display of force was appropriate. There is a dispute about whether this young boy was so distressed that he wet himself. While this does not seem improbable, I am not able to make any concluded factual findings on the material in front of me.
369. Mr KE said that many officers entered his room early in the morning. He complains that he was handcuffed and that his 17 year old son, Master KH, was also handcuffed. He says that his daughter, Ms KG, who was 19 years old, was not handcuffed but that she was led away with officers holding her under her arms and that she had bruises under her arms as a result of this.



370. Mr KE says that there were 30 or 40 officers in the corridor when he was taken out of his room. He says that he and his 17 year old son KH were taken to the property area. CCTV indicates that Mr KE's son was handcuffed using flexi-cuffs in front of his body and was initially escorted by two ERT officers in riot gear.



17 year old Master KH is escorted by two ERT officers while handcuffed.

371. The department said that Master KH was restrained for approximately 10 minutes with flexi-cuffs because he had been involved in 15 incidents of 'abusive and aggressive non-compliant behaviour' over the previous 20 months of detention. The Serco security risk assessment produced by the department showed that he had actually been involved in only six such incidents and that they appeared to be predominantly about use of strong language rather than instances of physical aggression. Descriptions of his 'abusive/aggressive behaviour' recorded in his security risk assessment include: 'swearing at officers', 'shouting at Serco staff member' and 'shouting in a different language and invading into a staff member's personal space'. The only incident of physical violence that he had been involved in in 20 months of detention was reported as 'minor detainee assaulted officer by pushing officer's hands'. His risk rating was medium.
372. As noted above, Mr KE's risk rating was low. The department said that he was handcuffed for approximately 30 minutes.
373. Mr KE says that he did not know where his wife, daughter and younger son were taken. He says that his elder son was put into a small mini bus and that at that point he was separated from his family. Mr KE says that he was taken to Darwin Police Station where there were interpreters. He says that he was placed in a room with around 7 other men and that one woman was detained in a separate room. After around 12 or 14 hours he was told that he would be transferred to Melbourne with his family.

374. In response to my preliminary view in this matter, the department maintained that the use of restraints on Master KH was appropriate, despite him being under 18 and not a high risk detainee. It also maintained that the use of restraints on Mr KE was appropriate despite him being a low risk detainee. The department said that it was 'reasonable in the circumstances for officers to consider that either may react negatively or resist their movement'. The department did not say whether any officers had in fact made this assessment. Such an assessment is not recorded in any of the documents provided to the Commission. As the department also acknowledged in its response to my preliminary view:

Detention policy and instructions require officers to use greater care than would otherwise be required should use of force on vulnerable people be warranted. Where the use of force may be required for detainees who are frail, elderly, or minors, service provider personnel are also required to take reasonable precautionary measures that are appropriate in the circumstances of the detainee to ensure their safety.

375. I find that flexi-cuffs should not have been applied to Mr KE. This was a 46 year old father of three with a low security rating. Prior to April 2015 he had only one incident of 'aggressive/abusive behaviour' in 20 months of detention. He was a highly compliant detainee. As noted previously in this report, the department's Detention Services Manual says that restraints should only be used on detainees who have a serious or violent criminal history, who have a history of escape or who potentially pose a high risk as indicated by their individual risk assessment. None of these criteria applied in relation to Mr KE. Having reviewed the CCTV footage, there is no evidence that Mr KE showed any resistance to officers. While Serco may have considered that the use of restraints on Mr KE was convenient in the context of the operation as a whole, the Detention Services Manual emphasises that instruments of restraint must never be used for convenience or as an alternative to reasonable staffing. It could not be said in the context of this operation that there were insufficient staff.

376. I find that the use of flexi-cuffs on Mr KE was inconsistent with and contrary to his rights under article 10 of the ICCPR to be treated with humanity and with respect for his inherent dignity.

377. Similarly, I am concerned about the use of flexi-cuffs on Master KH. This was a minor who did not have a history of violence and whose risk rating was medium. Both the JDL Rules and general comments from the United Nations Committee on the Rights of the Child provide that force should be used on children only in exceptional circumstances and where all other control methods have been exhausted and failed. Again, having reviewed the CCTV footage, there is no evidence that Master KH showed any resistance to officers. There is no evidence that Master KH was given the option of walking cooperatively with officers to the muster area. Rather, it appears that flexi-cuffs were applied at the first available opportunity.

378. In the circumstances, I find that the use of flexi-cuffs on Master KH was inconsistent with and contrary to his rights under article 10 of the ICCPR and article 37(c) of the CRC to be treated with humanity and with respect for his inherent dignity.

379. The CCTV footage suggests that Ms KG was compliant and walked with Serco officers without the need for any significant force to be applied. I am not satisfied that there was any use of force on her that was contrary to her human rights.

**(b) Impact on privacy**

380. Separately from the degree of force used, the family also complained that the way in which the operation was conducted was contrary to their right to privacy.

381. Ms KG, then aged 19, said that she was sleeping in her own room by herself next to the room occupied by her parents and youngest brother. She said that she was not given any previous notice of the transfer. She said that she was shaken awake in the early hours of the morning and was surrounded by a number of large heavily uniformed ERT officers. As their faces were all covered, she did not know if they were male or female. She said that they did not speak to her, and motioned to her not to speak. She said that she was only wearing a nightdress and asked if she could put on some clothes for modesty. She said that the ERT officers indicated that she could put on clothes but that she had to leave her bathroom door open while doing so. She said that they did not leave her room while she was dressing and that she put on clothes over her nightdress in front of the officers. Ms KG alleged that this experience was humiliating, culturally inappropriate and insensitive, and that it invaded her privacy.

382. Mrs KF said that she was sleeping in her bed with her husband and her youngest child, Master KI, then aged 9 years old, when she was woken up by ERT officers in her room. She said that when she opened her eyes, she saw her small room was filled with ERT officers. She said that she was taken out of bed by two officers and she did not know whether they were male or female as they were wearing full riot gear. She said that she felt terrified and believed her privacy had been invaded given that there was no advance notice that they would be removed. Mrs KF alleged that she was humiliated by the manner in which the extraction operation took place and that she has suffered psychological harm following the incident.

383. Mrs KF also complained that, after the transfer to Bladin the members of her family were subject to observation for two days, including being accompanied by a guard to the bathroom and not being able to close the cubicle door.

384. The family alleged that the privacy of Ms KG and Mrs KF was arbitrarily interfered with, contrary to article 17(1) of the ICCPR and that their treatment also amounted to a failure to treat them with humanity and respect for their inherent dignity contrary to article 10(1) of the ICCPR. In support of this argument, they rely on article 53 of the Standard Minimum Rules for the Treatment of Prisoners which establishes protocols that prioritise the importance of women in detention being attended and supervised by female officers.

385. Article 17(1) of the ICCPR provides that no one shall be subjected to arbitrary or unlawful interference with their privacy, family, home or correspondence.

386. The UN HR Committee in General Comment 16 on article 17(1) states that the 'concept of arbitrariness is intended to guarantee that even interference provided for by law should be in accordance with the provisions, aims and objectives of the Covenant and should be ... reasonable in the particular circumstances'.<sup>80</sup>
387. In relation to the meaning of 'reasonableness', the UN HR Committee said in *Toonen v Australia*:
- The Committee interprets the requirement of reasonableness to imply that any interference with privacy must be proportional to the end sought and be necessary in the circumstances of any given case.<sup>81</sup>
388. An interference with privacy will therefore be arbitrary if it is not reasonable. Reasonableness is assessed by considering whether the interference is necessary and proportional to achieving a legitimate purpose said to justify the interference.
389. Manfred Nowak in *UN Covenant on Civil and Political Rights CCPR Commentary*, says in relation to the obligation imposed on State parties by article 17(1) in respect of detainees that:
- Special obligations to fulfil the right to privacy by means of positive action and to protect it against interference by private parties arise in relation to persons deprived of personal liberty and other persons in a vulnerable position ... . Typical examples are the duty to ensure to prisoners and detainees a right to correspondence and communication with the outside world and to provide them with a minimum of privacy, intimacy and respect for their honour and reputation against interferences by prison wardens and other inmates alike.<sup>82</sup>
390. Families with children in immigration detention are in a vulnerable position and require positive action by those responsible for their detention to ensure that their privacy is not arbitrarily interfered with. This is particularly true for a young woman in the position of Ms KG.
391. Article 53 of the Standard Minimum Rules for the Treatment of Prisoners provides:
- (1) In an institution for both men and women, the part of the institution set aside for women shall be under the authority of a responsible woman officer who shall have the custody of the keys of all that part of the institution.
  - (2) No male member of the staff shall enter the part of the institution set aside for women unless accompanied by a woman officer.
  - (3) Women prisoners shall be attended and supervised only by women officers. This does not, however, preclude male members of the staff, particularly doctors and teachers, from carrying out their professional duties in institutions or parts of institutions set aside for women.
392. On 28 June 2018, the Commission sought a response from the department in relation to the privacy allegations. The department provided a written response on 15 August 2018.
393. The department confirmed that detainees, including Mrs KF and her daughter, were not given any notice that they would be removed from Wickham Point or of the manner in which they would be removed. The department said that in the case of the Wickham Point extraction 'operational security requirements ... over[rode] detainee notification requirements'.

394. The Commission asked for a response to the allegation that the ERT officers who entered Ms KG's room and Mrs KF's room had their faces covered and that, as a result, Ms KG and Mrs KF could not tell whether they were male or female. The department confirmed that the ERT officers who entered their bedrooms were wearing Personal Protective Equipment (PPE) including 'fire retardant overalls and balaclava, body armour and a helmet'. The balaclava, helmet and visor covered the face of these officers.
395. The Commission has reviewed CCTV footage of the extraction. It appears that at least four ERT officers wearing PPE enter Ms KG's room. Some officers exit the room shortly after entering it. Ms KG emerges from the room a minute and a half later wearing a pink top and grey pants followed by two ERT officers. When she comes out of her room, there are at least 12 ERT officers wearing helmets and body armour in the corridor.



Ms KG emerges from her room.

396. The Commission asked for a response to the allegation that when ERT officers entered Ms KG's room she was only wearing a nightdress and that she was required to leave the bathroom door open while putting on some clothes for modesty. The department said:
- Due to the early hour of the extraction, [Ms KG] was given the opportunity to add more clothing. Given that [Ms KG] was being extracted from the facility, there was a requirement for the bathroom door to remain open to prevent her from locking the door to avoid extraction, or to enable her to commit any act of self-harm.
397. At the time of the extraction, Ms KG's risk assessment was 'low' across all domains. She was assessed by Serco as a low risk of demonstration, a low risk of escape, a low risk of self-harm, a low risk of engaging in aggression or violence and she had no criminal profile.

398. The department did not provide a responsive answer to the allegation that this experience was humiliating for Ms KG, culturally inappropriate and insensitive. Instead, the department said that 'it was necessary for the Department to implement the proper controls to maintain the good order of the centre and the safety of all detainees and staff' and that 'these controls included the planned use of ERT officers, using personal protective equipment, with support from Northern Territory Police'.
399. However, ERT officers were also accompanied by other Serco officers, including some women, who were not wearing PPE.
400. I am not satisfied that a sufficient explanation has been given for why it was necessary in the context of this operation for at least four masked ERT officers to enter the bedroom of a teenaged girl unannounced before dawn and to refuse her the opportunity to get dressed without them being present. Ms KG was not sharing this room with anyone else. Serco had assessed her as being a low risk detainee, including a low risk of becoming aggressive or engaging in self-harm. Other options were readily available to officers engaged in the removal process. For example, a female officer not wearing PPE could have knocked on the door, announced who she was and entered the room alone to give Ms KG the opportunity to preserve her privacy. I note that a female officer, not wearing PPE, accompanied Ms KG's 9 year old brother as he was led through the corridors during the extraction.
401. I find that the way in which the operation was conducted was likely to be highly distressing for Ms KG. Reports of counselling by Foundation House, which specialises in counselling for survivors of torture and trauma, indicate that this event has had a psychological impact on her. A Foundation House counsellor noted that in June 2015 Ms KG described her distress at 'multiple officers [coming] to her room, waking her & forcing her out of her room'. She later described an inability to sleep, that she finds herself listing to noises outside her room and that she is easily startled. The counsellor noted:
- She describes [the] intrusive nature of the memory of officers coming into her room and feeling paralysed by fear. She describes that she often wakes up in this 'frozen' state. During this conversation [Ms KG] became very tearful and distressed, she stated that she continues to feel humiliated by this particular incident.
402. Ms KG reported to her counsellor that she remains fearful of men in uniform.
403. I find that the way in which officers entered Ms KG's room and their refusal to allow her the opportunity to get dressed without them being present was neither reasonable nor proportionate to a legitimate purpose. Alternative ways of proceeding were readily available that would not have involved this very significant interference with her privacy. I find that the conduct of the ERT officers in this situation was contrary to Ms KG's right to privacy under article 17(1) of the ICCPR.



Ms KG is led through a corridor by an ERT officer wearing PPE.

404. The Commission has viewed the CCTV footage of the extraction of Mrs KF. It appears that at least four ERT officers enter the room that she is sharing with her husband and her 9 year old son Master KI. She is led away by ERT officers less than half a minute later, leaving her husband and son behind. Master KI is led away separately about two and a half minutes behind his mother.



Master KI is led through the corridor past ERT officers by a female Serco officer not wearing PPE.



Master KI is led through the corridor past other Serco officers.

405. In response to the allegation that the experience was humiliating for Mrs KG, the department said that 'safety obligations will override other considerations'. It acknowledged that extraction without notice may at times potentially cause distress but said that 'such extractions are considered necessary to prevent detainees from undertaking further activities that may delay such an extraction'. This answer responds to the question about the lack of notice, but not the manner in which the extraction was carried out.
406. In response to the allegation that Mrs KG and her children were subject to continuous observation after their transfer to Bladin, including not being accompanied to the bathroom and not being permitted to close the cubicle door, the department said:
- Following the extraction, [Mrs KG] and family were monitored on their arrival at Bladin to ensure their own safety and security was not compromised by any acts of self-harm given the involvement of [Ms KF's] father ... in the disturbance.
407. At the time of the extraction, Mrs KG was assessed by Serco as a low risk of self-harm.
408. I accept that on occasion it may be necessary to arrange for people to be transferred from an immigration detention centre on short notice. The circumstances of this transfer, following on from a significant disturbance at Wickham Point over the previous three days, was exceptional.
409. The removal of Mrs KG, Mr KE and Master KI from their room had different characteristics from the removal of Ms KF from the room in which she was sleeping by herself. Mr KE, although a low risk detainee, had been identified as an 'instigator' of some of the protest action. I find that the circumstances in which Mrs KG was removed from her room did not amount to an arbitrary interference with her privacy, contrary to article 17(1) of the ICCPR. I do not have sufficient information to determine whether the treatment of Mrs KG and her children while detained at Bladin overnight was contrary to their right to privacy.



410. Nevertheless, I have concerns about how this extraction operation was carried out. In particular, I consider that the pre-dawn operation involving more than 20 heavily armoured ERT officers and around 30 other Serco officers appeared excessive to the task of removing four low risk family groups from a family compound. The display of force was likely very intimidating for those detained at the centre, particularly for children.

## 11.2 Case study: Ms LC and her family

411. Ms LC, her husband and their new born baby daughter (then 37 days old) were removed from Wickham Point as part of the extraction on 18 April 2015. Ms LC and her husband are from Iran and arrived in Australia by boat as asylum seekers in August 2013. They were initially transferred to Nauru, but were returned to Australia so that Ms LC could give birth to her daughter. Ms LC was identified by Serco as one of three people who were the 'main instigators who were demanding the return of the two family groups' that were being sent to Nauru. In the Serco planning document for the extraction, Ms LC's relevant activity is described as 'spokesperson' rather than 'agitator'. Of the seven identified detainees of interest, she was identified as being of 'Priority 1'. She denies that she was involved in organising the protest.
412. Ms LC says that on 15 April 2015 she went to an interview room for a telephone call and saw two other families locked in another interview room because they were being transferred back to Nauru. She says that she felt anxious and upset about this and asked to go back to her room but that she was not permitted to do so and was required to stay in the interview room. She says that she was taken to the medical centre:
- From here, I saw that other people started a protest because of these transfers. I saw a lot of people angry. They broke the gate, went on the rooftops and sought to enter the interview rooms to save these families from being transferred.
413. Ms LC says that as the protest escalated, she helped interpret between the Centre Manager and the protesters.
414. On 18 April 2015, Ms LC says that she was taken from her room by Serco officers, handcuffed, taken to a police station in Darwin and put in cell by herself. She says that Serco was aware that she had been clinically diagnosed with postnatal/postpartum depression and that she suffered from depressive symptoms, hyperventilation and panic attacks. She says that these vulnerabilities were not taken into account by Serco during the extraction when decisions were made to handcuff her and separate her from her family. She complains that she was separated from her husband and their baby who were taken to Bladin immigration detention facility, also in Darwin:
- At 4pm, I was able to speak to my husband who had been transferred to Bladin IDC with our baby. He told me that she had her last milk at 2am as I did not get to feed her before I left the centre. As my husband was not allowed to take the milk I had expressed from the fridge he had to give my baby formula. ... I am upset that they separated me from my baby who I was not able to care for and breastfeed.
415. Ms LC was distressed that her baby had to be provided formula when breast milk was available. She felt that without having her milk available, her baby was missing out on a connection with her while they were physically separated.

416. Ms LC says that she was not given any notice that the family would be removed from Wickham Point. She says that when ERT officers entered her room before dawn, she was told she had to move immediately. CCTV shows that Ms LC was escorted from her room by three ERT officers.



Ms LC escorted from her room by ERT officers.

417. At the outset, Ms LC appears to walk with the guards with minimal contact. Later, she appears to be resisting and arm holds appear to be used. Several minutes later, it appears that her husband, carrying their baby, is escorted by two other Serco officers each with a hand on the back of one of his arms.



Ms LC being escorted by Serco officers using arm entanglements.

418. Use of force reports produced by the department show that Ms LC was initially moved from her room to a muster point by two Serco officers 'using the approved C&R [control and restraint] transport hold'. At the muster point, mechanical restraints were applied before she was put into a Serco vehicle to the Darwin police station. The department says that the use of handcuffs on Ms LC 'was required as [she] had been identified as one of the instigators of the disturbance at the facility which the Northern Territory (NT) Police were notified of and responded to'. It says that the handcuffs were applied by Serco for an hour and 40 minutes from 5.45am to 7.25am and were removed when she arrived at the police watch-house.
419. The department acknowledges that Ms LC was separated from her baby for approximately 32 hours from 5.40am on 18 April 2015 until she boarded an aircraft to Melbourne which departed Darwin at 1.42pm the following day, 19 April 2015. It says that staff involved in the extraction operation were not advised that the baby was being breastfed or that Ms LC had expressed milk for her baby. It says that Ms LC's husband requested and was provided baby formula for the baby.
420. Ms LC says that while she was detained at the police watch-house, she was visited by 'the head of Case Management'. She says that she asked to contact her lawyer but that this request was denied. The department says that it 'made a decision not to allow Ms LC to contact her lawyer in order to ensure good order for the transfer operation and for the safety of detainees and staff. This was actioned through the temporary restriction of access to telephone and internet facilities during this extraction operation'.
421. I find that there was no demonstrated need to handcuff Ms LC. Prior to the disturbance at the centre, Ms LC's security rating was 'medium'. According to Serco's Post Incident Review, this was the result of 'a number of reported incidents including self-harm, major disturbances and contraband finds'. Ms LC emphasised that 'contraband' is interpreted broadly in immigration detention. She says that she can't recall what items this related to but says that she never had any dangerous objects. As a result of being identified as a 'spokesperson' during the disturbances, her security rating was raised to 'high'. It does not appear that she had been involved in any acts of aggression or violence. Although she resisted being walked to the muster point on the day of the extraction, Serco officers were able to escort her there without incident using approved control and restraint holds. This escort took approximately 2 minutes. I am not satisfied that a sufficient explanation has been provided for why restraints were then necessary for the transfer by van to the police watch-house where the restraints were removed. I find that the application of restraints for an hour and 40 minutes during the course of this journey was contrary to her rights under article 10 of the ICCPR to be treated with humanity and with respect for her inherent dignity.

422. I am also concerned that Ms LC was separated from her 37 day old baby for a period of 32 hours. In response to Ms LC's allegation, the department initially referred to her medical records and said that on 10 April 2015, when the baby was 29 days old, she had asked to be allowed to sleep in a separate room from her husband and baby. The implication seemed to be that if she had requested to sleep in another room from her husband and her baby, then there should be no issue in physically separating the family during the extraction for an extended period of time. I do not accept this implication. Ms LC's medical notes indicate that she was suffering from postpartum depression which was being exacerbated by waking throughout the night as her baby was having difficulty settling. This was the reason that she requested a change in sleeping arrangements. I fail to see how those sleeping arrangements could be seen to justify a decision to separate Ms LC from her baby.

423. After the completion of my investigation, and in response to my preliminary view in this matter, the department raised the following issue, for the first time:

[Ms LC] had made multiple threats to harm both herself and her child. As a result, the department held serious concerns for the child's welfare if left in her mother's care during the transfer operation. It was assessed to be in the best interests of the child that at all times the baby remain with her father, who was provided with all necessary support.

424. This new allegation is very serious. Previously, the department had claimed that: '[Ms LC] was separated from her baby when she was escorted from Wickham Point to the NT Police Watch House on 18 April 2015 as a result of her involvement in the disturbance at the facility. [Ms LC] was separated from her baby until she boarded the aircraft (to be transferred to Melbourne) on 19 April 2015'.

425. I have considered the new allegation made by the department against the records provided during the course of the inquiry. None of the records produced by the department records a decision to separate Ms LC from her baby on 18 April 2015 because of a concern for the safety of the baby. After the department raised this new issue, the Commission sought further documents about it. The department confirmed that it 'is unable to locate specific evidence to show consideration of the best interests of the child'. Given this admission, I consider that the new allegation should not have been made.

426. Four days prior to the extraction, Ms LC was involved in an incident at the canteen. An incident report produced by Serco says:

At approximately 1710 hours on the 14.04.15 it was reported to Centre Manager ... by Canteen staff ... that detainee [Ms LC] went to canteen to buy 3 phone Cards from [her baby's] Identification Card.

At approximately 1550 hours [sic] during the conversation [Ms LC] stated that whenever her baby cry's she looked at her and wants to harm her. However, didn't specified how she is going to harm her.

Mental Health was notified about this incident and IHMS Mental reassured that they are aware of her clinically diagnosed Post natal depression.

Serco placed [Ms LC] on keep safe constant due to safety and welfare concern of [her baby]. ...

Northern Territory and children services were notified about the incident ... .

427. It was appropriate for notifications to be made to relevant bodies following any reported threat involving a child, regardless of the circumstances. Upon receipt of that report, IHMS noted that this comment was likely the result of Ms LC's post natal depression. Ms LC was monitored following this comment, but no steps were taken to separate her from her baby over the next three and a half days until they were extracted.
428. In the Operational Concept document produced by Serco on 17 April 2015 in relation to the extraction, there is no reference to the need to separate Ms LC from her baby for the safety of the baby. In the use of force report about the actual extraction of Ms LC, there is no reference to a decision to separate Ms LC from her baby. Ms LC and her baby were reunited on the flight to Melbourne on 19 April 2015. There are no records that suggest that there was a need to separate them on the flight, or following arrival at Melbourne Immigration Transit Accommodation in Melbourne. The department confirmed that no other steps were taken to separate Ms LC from her baby. Even if the department had held continuing concerns for the safety of Ms LC's baby, there would have been ways of dealing with such a concern that did not involve separating the baby from her mother. For example, an additional support person could have been provided.
429. I consider that the most likely reason that Ms LC was separated from her baby during the extraction operation is that Serco determined that she, along with six other people identified as 'the main instigators' were to be taken to the police watch-house rather than Bladin. I have not been provided with any record that suggests that any consideration was given to the rights of Ms LC's baby during the course of the extraction. Contrary to the submission by the department in response to my preliminary view, I am not satisfied that there was any decision made to separate Ms LC from her baby during the extraction because of 'serious concerns for the child's welfare'.
430. Article 9 of the CRC provides that states should ensure that a child is not separated from his or her parents against their will, except where competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. Prior to receiving my preliminary view in this matter, the department had not suggested that the separation of Ms LC from her baby was in the best interests of the child. For the reasons set out above, I am not satisfied that the new allegation by the department should be accepted. I find that the separation of Ms LC from her baby was inconsistent with and contrary to the rights of the child under article 9 of the CRC.
431. Finally, I am concerned that Ms LC was denied access to a lawyer. On this issue, the CPT has provided the following guidance:

The possibility for persons taken into police custody to have access to a lawyer is a fundamental safeguard against ill-treatment. ...

To be fully effective, the right of access to a lawyer should be guaranteed as from the very outset of a person's deprivation of liberty. Indeed, the CPT has repeatedly found that the period immediately following deprivation of liberty is when the risk of intimidation and physical ill-treatment is greatest.<sup>83</sup>

432. I note that s 256 of the Migration Act provides, relevantly, that:

Where a person is in immigration detention under this Act, the person responsible for his or her immigration detention shall, at the request of the person in immigration detention, ... afford to him or her all reasonable facilities ... for obtaining legal advice or taking legal proceedings in relation to his or her immigration detention.

433. In *NAFC v Minister for Immigration and Multicultural and Indigenous Affairs* Beaumont J described the obligation in s 256 as 'a free-standing guarantee, which must be given its own effect, wherever the detainee is held'.<sup>84</sup>

434. Similar rights exist at common law<sup>85</sup> and under international human rights law. In particular, the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment relevantly provides:

Principle 17

1. A detained person shall be entitled to have the assistance of a legal counsel. He shall be informed of his right by the competent authority promptly after his arrest and shall be provided with reasonable facilities for exercising it.

Principle 18

1. A detained or imprisoned person shall be entitled to communicate and consult with his legal counsel.
2. A detained or imprisoned person shall be allowed adequate time and facilities for consultation with his legal counsel.
3. The right of a detained or imprisoned person to be visited by and to consult and communicate, without delay or censorship and in full confidentiality, with his legal counsel may not be suspended or restricted save in exceptional circumstances, to be specified by law or lawful regulations, when it is considered indispensable by a judicial or other authority in order to maintain security and good order.

435. As noted in paragraph 28 above, at least some of these principles have been determined to be minimum standards regarding the conditions of detention when considering the requirements of article 10 of the ICCPR.

436. The department says that it considered and denied Ms LC's request to speak with a lawyer 'to ensure good order for the transfer operation and for the safety of detainees and staff'. By this stage, Ms LC was already in custody in the police watch-house. I do not see how granting a request to speak with a lawyer while she was detained there posed any risk to the safety of detainees or staff. I find that there was no adequate justification for a refusal to allow access to legal advice and that the denial of this request was contrary to her rights under article 10 of the ICCPR to be treated with humanity and with respect for her inherent dignity.

### 11.3 Case study: Mrs MD and Mr ME

437. Mrs MD and her husband Mr ME were removed from Wickham Point as part of the extraction on 18 April 2015. They are from Iran and had arrived in Australia by boat as asylum seekers in August 2013. They were taken to Nauru for seven months before being returned to Australia so that Mr ME could obtain medical treatment. Mr ME was identified by Serco as 'an agitator and spokesperson that instigated or facilitated the events at Wickham Point APOD on 15 April 2015'. Of the seven identified detainees of interest, he was identified as being of 'Priority 2'. The only incidents that Mr ME had been involved in during his time in detention to that point had been two incidents of threatened self harm. He had no incidents of abusive or aggressive behaviour or any act of violence in approximately 20 months of detention.
438. Mrs MD claims that Mr ME has been diagnosed with schizophrenia and has auditory hallucinations. The department disputes this and says that as at early 2016 Mr ME's diagnosis was 'mixed anxiety with depression' and that his most recent psychiatrist report concluded that his auditory hallucinations 'are likely to be borne out of stress and not suggestive of a primary psychotic disorder'. There is some support in Mr ME's medical records for both of these positions. From 26 February 2015 Mr ME spent five weeks as an intensive psychiatric inpatient in Toowong Private Hospital. Mrs MD claims that Mr ME's treating doctors said that it was not appropriate for him to be in detention. The discharge report from a consultant psychologist at the hospital said:
- [Mr ME] is in a stressful situation and his presentation is probably best conceptualized as a behavioural reaction to his circumstances. As a differential diagnosis, he could perhaps be described as experiencing an adjustment disorder. ...
- I do not believe that further periods of psychiatric hospitalization would be of assistance to [Mr ME]. ... Although he is at some risk of carrying out his vague threat to harm himself in some non-specific manner should he be returned to detention, I would see this as a behavioural issue and not a symptom of mental illness.
439. When Mr ME was discharged from hospital he was returned to immigration detention at Wickham Point. The day that he was returned to immigration detention, he was placed on psychological support program monitoring at the highest level – High Imminent – by IHMS, the department's health service provider in immigration detention. In early April 2015, an IHMS psychiatrist following a 'thorough file review and consultation' considered that Mr ME had a 'schizoaffective disorder, bipolar type'. Later psychiatric assessments queried this diagnosis as described in the department's submissions.
440. Mrs MD says that she and her husband participated in a peaceful protest on 15 April 2015. She says that they were protesting about the department transferring two families with children to Nauru. The department denies that the protest was peaceful and says that it involved 'significant, deliberate and coordinated disruptive behaviour within the facility, which threatened the safety and good order of the facility'.

441. Mrs MD says that on 16 April 2015 two detainee representatives met with the department about the detainees' concerns. She says that some of the detainees became worried and that some climbed onto the roof, including Mr ME. She says that:

Serco officers tried to stop him and when they grabbed him he hit his head on the wall and became unconscious. An ambulance was called and he was treated at Wickham Point.

442. A Serco report from 15 May 2015 said that there was CCTV footage of Mr ME 'being carried into medical by staff' on 16 April 2015. The Commission sought CCTV footage of the incident but the department said that there was no footage available.

443. The department produced an incident report. The report said that on 16 April 2015 Mr ME was attempting to climb up on the roof during a disturbance in Sand compound. The report said that Mr ME was standing by the railing on the top floor when he attempted to climb onto the roof. Three officers attempted to stop him from climbing any further. The report noted that: '[a]s the Officers were attempting this, the officers and [Mr ME] lost their footings and fell and as they fell the detainee hit his head on the side of the demountable'. Mr ME initially appeared not to be responding and was taken to the medical clinic where an ambulance was called. According to the departmental incident report, attending ambulance officers assessed Mr ME and confirmed that there were no injuries sustained and that, despite having fallen and hit his head, Mr ME was possibly 'acting'. This incident report appears to be inconsistent with Mr ME's medical records. Mr ME was later seen by IHMS who recorded that he had 'obvious bruising to the side of face and leg'. In the absence of CCTV footage, and faced with different accounts of the incident, I am not able to be satisfied that this incident involved a breach of Mr ME's human rights.

444. On 18 April 2015 a group of officers came to their room early in the morning and handcuffed Mr ME using flexi-cuffs. CCTV footage shows:

- Mrs MD being removed from her room. She has no shoes and is being led by two guards, one on each arm. She does not appear to have flexi-cuffs on. She appears to be calling out at points. The guards are moving her more quickly than she can keep up at times and she is stumbling.
- Mr ME being removed from his room. He is being led by two guards, one on each arm. He has flexi-cuffs on and appears to be compliant. He is led into a muster room where he waits for around an hour sitting in a chair along with other detainees. The flexi-cuffs are replaced with mechanical cuffs and he is placed into a police wagon.

445. Mr ME was taken to the Darwin watch-house and detained in a cell with a number of other men. Mrs MD was taken to Bladin. The following day they were transferred to immigration detention in Melbourne.

446. The Commission asked whether Mr ME's mental health was taken into account in deciding to take him to the police watch-house. The department said that:

[Mr ME's] transfer to the NT Police Watch House did take into account his individual circumstances but was primarily based on operational need at the time which was to transfer the detainees to another detention facility who were posing a high risk to the good order of the centre.



447. The department did not produce any records setting out the consideration of Mr ME's individual circumstances. As set out in paragraphs 358 to 361 above, the documents produced by the department in relation to this operation do not show that there was any individualised consideration of the use of restraints for any of the detainees removed from Wickham Point.
448. I find that the use of flexi-cuffs and mechanical restraints on Mr ME was not appropriate in the circumstances. Further, I am not satisfied that his mental health issues were sufficiently taken into account during the extraction. Mr ME did not have any history of abusive, aggressive or violent behaviour. He had only recently been returned to immigration detention after five weeks as an intensive psychiatric inpatient in a private hospital. At the time, his current diagnosis was of a schizoaffective disorder, bipolar type. I find that the application of restraints on him was contrary to his rights under article 10 of the ICCPR to be treated with humanity and with respect for his inherent dignity.

## 11.4 Case study: Mrs NL and Mr NM

449. Mrs NL, her husband Mr NM and their three month old son were removed from Wickham Point as part of the extraction on 18 April 2015. Mrs NL and Mr NM are from Iran and had arrived in Australia by boat as asylum seekers in November 2013. They were taken to Nauru for 8 months before being returned to Australia so that they could obtain medical treatment. Their son was born in Royal Darwin Hospital in January 2015. At the time that they were removed from Wickham Point, Mr NM was 32 years old.
450. Mrs NL says that she and her husband participated in a peaceful protest on 15 April 2015. She says that they were protesting about the department transferring two families with children to Nauru. Mr NM was identified by Serco as one of the 'agitators' of the disturbance on 15 April 2015. Of the seven identified detainees of interest, he was identified as being of 'Priority 2'. The department says that Mr NM can be seen on CCTV kicking an interview room door, inciting other detainees and speaking with the Operations Manager. CCTV appears to show a man that could be Mr NM kicking a door marked IP 11 and gesticulating. There is no sound accompanying the video.
451. Prior to the disturbance on 15 April 2015, Mr NM had a security rating of 'medium'. He had been involved in five incidents of 'abusive/aggressive behaviour' primarily consisting of swearing or verbal abuse and one 'minor assault' on another detainee in 13 months of detention. After the disturbance, his security rating increased to 'high', which included a 'high' placement and a 'high' escort risk. Notes on his security assessment say that Mr NM 'was reported as being one of the main offenders' in the disturbance and that he 'was in possession of a weapon' during the disturbance.
452. On 18 April 2015 a group of officers came to their room early in the morning and handcuffed Mr NM using flexi-cuffs. The department says that Mr NM was restrained using flexi-cuffs 'to prevent injury to himself or others'. The flexi-cuffs were used for approximately 37 minutes, after which they were exchanged for mechanical restraints in preparation for police escort to the watch-house. The department says that NT Police applied standard issue handcuffs for the transfer of Mr NM from Wickham Point to the watch-house on 18 April 2015, which took approximately 1 hour. CCTV appears to show the handcuffs being applied by Serco ERT officers rather than by NT Police.

453. Based on the information available to me, I am not satisfied that the use of restraints on Mr NM was disproportionate in the circumstances. There is video evidence that Mr NM was behaving in an agitated way during the course of the disturbance. The Commission has not been able to locate any video evidence that he was carrying a weapon, but there were intelligence reports to that effect at the time and it was reasonable for Serco to rely on those reports.
454. Mrs NL complains that she was separated from their 3 month old baby during the extraction on 18 April 2015. CCTV appears to show Mrs NL being led down a corridor by two officers, one on each arm. Her hands are not restrained. She appears distressed. A third officer walks behind them and a fourth officer is following her carrying a baby. The department says that Serco staff 'assisted' Mrs NL during the extraction operation and transfer to Bladin APOD 'by holding the baby while remaining in very close proximity to [Mrs NL]'. This process took around an hour. The department says that at no point were mother and baby separated. The department says that on arrival at Bladin, provisions were supplied to all detainees at that location including baby welfare items and baby formula.
455. Ideally, Mrs NL would have been permitted to carry her son during the course of the extraction. It appears from the CCTV that Mrs NL was providing some resistance to the officers escorting her. The officers appear to use no more force that is necessary in the circumstances. As a result of the resistance given by Mrs NL, I am not satisfied that it was disproportionate for Serco to determine that she be physically escorted by two officers with another officer in close proximity carrying her baby.

## 11.5 Other issues

456. There are two other issues that arise in relation to the Wickham Point extraction that it is necessary to refer to. The first relates to the scale of the operation and the nature of the display of force by Serco. The second relates to evidence in the video provided to the Commission that restraints were used on two men with mobility issues who were in wheelchairs.

### (a) Display of force

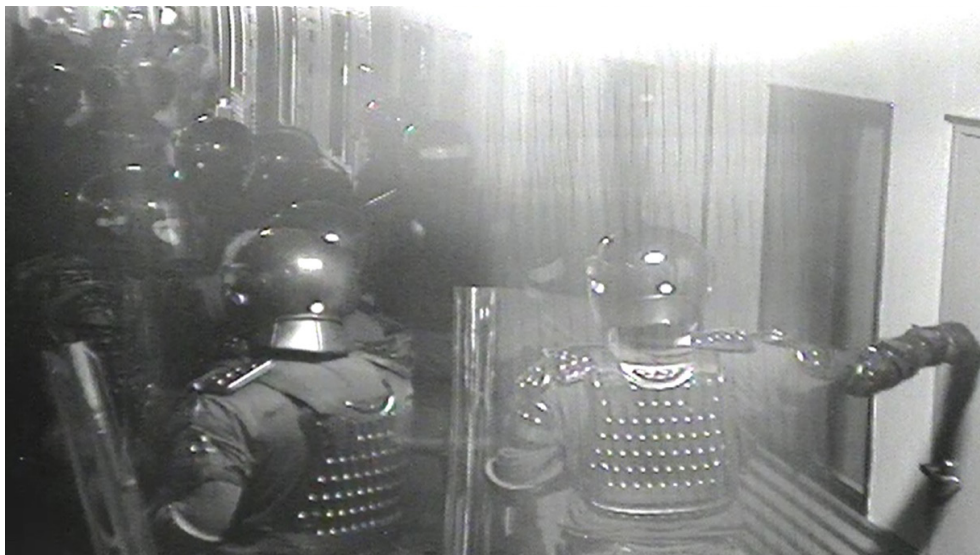
457. The department has a range of different detention facilities as part of its network. The most secure facilities are 'immigration detention centres' or IDCs. Only adults are detained in facilities classified as IDCs. Other facilities are classified as 'alternative places of detention' or APODs. Wickham Point was initially built as an IDC, however, on 11 July 2013 it was reclassified as an APOD which permitted it to be used to accommodate families with children in addition to single adults. At the time of the extraction in April 2015, Wickham Point had a compound that held single adult males and a compound that held families and single adult females.

458. The extraction was of 19 people from the families compound. The families compound at Wickham Point in April 2015 was predominantly, if not entirely, made up of asylum seekers. These were not people who had had their visas cancelled, for example on character grounds. The Commission received complaints on behalf of 13 of the people removed. Prior to the disturbance at Wickham Point, none of the complainants had a high security risk rating. They were described as 'low to medium risk placement Iranian detainees'. They comprised 9 adults (one of them, Ms KG, was a young woman of 19 years of age) and 4 children. Two of the children were babies aged 37 days and three months respectively. The other two children were a nine year old boy and a 17 year old boy. The Commission understands that of the other six people removed from Wickham Point who did not make a complaint to the Commission, two of them were a mother and her baby.
459. Wickham Point was not intended to be a high security centre and did not accommodate high security detainees in the family compound. However, the way in which the extraction was conducted had the feeling of a paramilitary operation. The operation commenced before dawn. There were more than 20 heavily armoured ERT officers. Many of them appeared to be wearing balaclavas under their helmets such that their faces, other than their eyes and nose, were concealed.



ERT officers with plastic shields and balaclavas.

460. Eleven of the ERT officers carried large plastic shields. When detainees were removed from their rooms, they were immediately confronted by massed ranks of these ERT officers.



ERT officers wait in corridor for detainees to be removed from their rooms.

461. The ERT officers were accompanied by around 30 Serco officers. As detainees were led away from their rooms the ERT officers passed them off to Serco officers who escorted them to the muster area. This was a very significant display of force. It was likely very intimidating for those detained at the centre, particularly for children. Many of these children were already traumatised as a result of their detention both in Nauru and at Wickham Point.<sup>86</sup>
462. In response to my preliminary view in this inquiry, the department said:

[E]ven though the transfer operation involved family groups, it was necessary to implement proper controls, including the planned use of the Serco Emergency Response Team (ERT) officers using approved personal protective equipment, to minimise the risk of individualised or collective disruptive behaviour during the transfer operation.

463. In light of the nature of the cohort of people detained at the Wickham Point, including the circumstances of their detention and their objective risk, there are real questions about whether such a significant display of force as was shown in the April 2015 extraction was appropriate.

**(b) Handcuffing people in wheelchairs**

464. I am also concerned that two men who were using wheelchairs were handcuffed while in their wheelchairs during the extraction.



One detainee in a wheelchair with flexi-cuffs on his wrists is led through a corridor by Serco officers during the extraction.



A second detainee in a wheelchair with flexi-cuffs on his wrists is led through a corridor by Serco officers during the extraction.

465. Further, it appears from relevant incident reports that at least some officers directly involved in the transfer of these detainees were not aware of their identity or their individual circumstances. This is another reflection of the lack of individual assessment of the necessity for particular people to be restrained. For example, one officer's report produced by the department said:

At approximately 0535 I held the wheelchair of an unknown detainee while he was handcuffed with flexi-cuffs, I then helped move his wheelchair out of the room to waiting Wickham Point IDC CSO's.

466. CCTV footage of the muster point near the Sally Port shows that two of the detainees were brought there in wheelchairs while wearing flexi-cuffs. Officers then replaced the flexi-cuffs with mechanical restraints before the detainees were taken to the police watch-house.

467. As noted in paragraph 70 above, in the UK there is a presumption against the use of handcuffs where a detainee's mobility is severely limited, for example when they are on crutches. This reasoning applies with even more force when a person requires the use of a wheelchair. In such circumstances, it is very difficult to see why the use of handcuffs could be considered appropriate.

468. It does not appear that guidelines promulgated by the department or Serco in Australia specifically deal with this issue. The closest reference appears to be a requirement that Serco ensure that whenever force is used on detainees that are frail, elderly or minors it must take all reasonable precautionary measures to ensure the safety of the detainee that are appropriate.

## 12 Findings and recommendations

469. Where, after conducting an inquiry, the Commission finds that an act or practice engaged in by a respondent is inconsistent with or contrary to any human right, the Commission is required to serve notice on the respondent setting out its findings and the reasons for those findings.<sup>87</sup> The Commission may include any recommendation for preventing a repetition of the act or a continuation of the practice.<sup>88</sup>

470. The Commission may also recommend:

- the payment of compensation to, or in respect of, a person who has suffered loss or damage; and
- the taking of other action to remedy or reduce the loss or damage suffered by a person.<sup>89</sup>

471. I consider that it is appropriate to make recommendations directed both at remedying or reducing the loss and damage suffered by the individual complainants and their families, and at preventing a repetition of the acts or a continuation of the practices that are described in my findings.

472. In some cases, I have made a recommendation for the payment of compensation to individuals or families. While the loss and damage suffered by the complainants will not be able to be fully addressed by the payment of money, I consider that it is important that they be provided compensation to acknowledge the impact that their treatment by the Commonwealth has had on them.
473. In considering the assessment of a recommendation for compensation under s 35 of the AHRC Act (relating to discrimination matters under Part II, Division 4 of the AHRC Act), the Federal Court has indicated that tort principles for the assessment of damages should be applied.<sup>90</sup> I am of the view that this is the appropriate approach to take to the present matter. For this reason, so far as is possible in the case of a recommendation for compensation, the object should be to place the injured party in the same position as if the wrong had not occurred.<sup>91</sup>
474. The Commission has set out in other inquiries the jurisdictional basis for the Commission to make recommendations for the payment of compensation and the available administrative avenues for the payment of such compensation by the Commonwealth.<sup>92</sup> I do not repeat those matters again here.

## 12.1 Position of the complainants

475. I have found a breach of human rights in relation to six individual complainants and three family groups. I deal below with the impact of the breach of human rights on each of them and the action that I recommend the department take in order to remedy or reduce the loss or damage suffered as a result.

### (a) Mr AY

476. I found that Mr AY was required to wear handcuffs over a significant wrist wound for approximately 8 and a half hours during a transfer between immigration detention facilities in Sydney and Western Australia and that the use of handcuffs in these circumstances contributed to his pain and discomfort and was contrary to his rights under article 10 of the ICCPR to be treated with humanity and with respect for his inherent dignity.
477. Mr AY is currently living in the community in Australia. Mr AY says that he and his partner both suffer from depression and post-traumatic stress disorder as a result of the circumstances of Mr AY's detention in general and his treatment during the course of this transfer in particular. They have both been seeing a psychologist. Mr AY says that they have both had nightmares about the transfer incident and other incidents that occurred during Mr AY's detention. He says that his partner has been unable to work full-time since the transfer because she becomes overwhelmed and stressed.
478. I do not have copies of medical records relating to Mr AY but I accept that the transfer was a traumatic incident for him because of his separation from his then fiancée, the lack of explanation of the need for the transfer or its duration, and the requirement that he be handcuffed over a significant wrist wound for many hours.

479. Mr AY sought the following recommendations:

- Mr AY said that he had made an application for a partner visa more than two years ago and that this application is yet to be determined. I understand that he and his partner were married in August 2018. He submits that the grant of a partner visa would allow both he and his partner to begin to heal from this incident.
- Mr AY seeks compensation for the loss and damage he has suffered as a result of the breach of his human rights.
- Mr AY seeks a review of the department's and Serco's policies regarding use of force and handcuffs, security assessments and the administration of medical attention with a view to aligning them with Australia's international obligations.

480. I consider that the first of these recommendations is beyond the scope of this inquiry which has focused on the use of force in immigration detention. The question of Mr AY's partner visa was not raised earlier in the inquiry. As a result, the department was not asked to respond to questions about it. In the circumstances, I do not have enough information to determine whether or not the process of assessing Mr AY's application for a partner visa has been appropriate.

481. I consider aspects of the third of these proposed recommendations in the following sections dealing with systemic issues arising from this inquiry.

482. I make the following recommendation dealing with Mr AY's particular circumstances:

- I recommend that the Commonwealth pay to Mr AY an appropriate amount of compensation to reflect the loss and damage he has suffered as a result of the breaches of his human rights identified in the course of this inquiry.

**(b) Mr CE**

483. I found that Mr CE was required to wear handcuffs for more than 12 hours during flights between Christmas Island and Melbourne via Perth and that this was contrary to his rights under article 10 of the ICCPR to be treated with humanity and with respect for his inherent dignity.

484. Mr CE was removed from Australia in July 2018. Prior to his removal, he made submissions about the kinds of recommendations that he was seeking in this inquiry. Mr CE said that he objected to detainees being handcuffed when they were transferred between centres. He said that this amounted to treating detainees like criminals. He said that when people were being transferred between centres they should not be handcuffed. I make some recommendations in relation to the practice of handcuffing detainees below.

485. Mr CE has not identified any medical issues that arose as a result of the use of handcuffs on him, however, I accept that the prolonged use of handcuffs was unnecessary and was distressing for him.



486. I recommend that the Commonwealth pay to Mr CE an appropriate amount of compensation to reflect the loss and damage he has suffered as a result of the breaches of his human rights identified in the course of this inquiry.

**(c) Mr DB**

487. I found that Mr DB was required to wear handcuffs in order to attend external medical appointments and that this was contrary to his rights under article 10 of the ICCPR to be treated with humanity and with respect for his inherent dignity.

488. Mr DB was removed from Australia in November 2016.

489. Mr DB has not identified any medical issues that arose as a result of the use of handcuffs on him, however, I accept that the requirement that he wear handcuffs to attend external medical appointments was unnecessary and was distressing for him.

490. I recommend that the Commonwealth pay to Mr DB an appropriate amount of compensation to reflect the loss and damage he has suffered as a result of the breaches of his human rights identified in the course of this inquiry.

**(d) Mr EJ**

491. I found that Mr EJ was required to wear a face mask during an attempt to deport him to China and that this was disproportionate to any risk faced and was contrary to his rights under article 10 of the ICCPR to be treated with humanity and with respect for his inherent dignity.

492. Mr EJ was later successfully removed from Australia in February 2015.

493. Mr EJ has not identified any medical issues that arose as a result of the use of force on him, however, I accept that the requirement that he wear a face mask during the first attempt to remove him from Australia was humiliating and distressing for him.

494. I recommend that the Commonwealth pay to Mr EJ an appropriate amount of compensation to reflect the loss and damage he has suffered as a result of the breaches of his human rights identified in the course of this inquiry.

**(e) Mr FE**

495. I found that force was used on Mr FE while he was detained at Christmas Island Immigration Detention Centre in a situation where it was unnecessary. The use of force included the application of downward force to Mr FE's head while it was in contact with the concrete floor which caused his implanted tooth to be dislodged. I found that these acts were contrary to Mr FE's rights under article 10 of the ICCPR to be treated with humanity and with respect for his inherent dignity.

496. Mr FE was removed from Australia in July 2017.

497. The use of force on Mr FE resulted in his implanted tooth being dislodged and him bleeding from the mouth.

498. I recommend that the Commonwealth pay to Mr FE an appropriate amount of compensation to reflect the loss and damage he has suffered as a result of the breaches of his human rights identified in the course of this inquiry.

**(f) Mr HF**

499. I found that force was used on Mr HF at the conclusion of an interview with him about the need for him to move rooms while he was detained at Maribyrnong Immigration Detention Centre. I found that force was not used as a last resort; that other communication, negotiation and conflict de-escalation strategies could and should have been attempted; and that the failure to use force as a last resort was contrary to Mr HF's rights under article 10 of the ICCPR to be treated with humanity and with respect for his inherent dignity.

500. Mr HF was removed from Australia in August 2017.

501. Mr HF claims that the use of force on him resulted in a chronic shoulder injury. He says that he is on medication for depression as a result of the incident and is taking pain killers and attending physiotherapy for his shoulder injury.

502. During the course of the inquiry, with the consent of Mr HF, the Commission obtained medical records made during his time in immigration detention. Medical records from IHMS showed that after the use of force incident Mr HF complained of 'moderate' pain in his right shoulder and denied any other symptoms. A primary health nurse recorded that Mr HF was moving his shoulder with minimal effort and that he did not seem to be stressed by the pain. The nurse gave him 1g of paracetamol. Subsequent medical records the following day and 12 days after the incident referred to Mr HF experiencing headaches, but there was no subsequent mention of ongoing shoulder problems.

503. Approximately a month after the incident, Mr HF reported to IHMS with a sore right shoulder. He said that he had bumped his shoulder on the shower door. There is no mention in the notes of the previous use of force incident. He was again given paracetamol.

504. After receiving my preliminary view in this matter, Mr HF said that he was seeking compensation for the injury to his shoulder. He suggested that the Commission obtain medical records from his time in prison following his release from immigration detention. The Commission asked Mr HF on several occasions to provide an authority to obtain these medical records, but Mr HF did not provide that authority.

505. In the circumstances, I am unable to be satisfied that the use of force on Mr HF resulted in a chronic shoulder injury. I have found that the use of force was avoidable and was not necessary in the circumstances but I do not consider that it is appropriate to also recommend that the Commonwealth pay compensation to Mr HF.

**(g) Mr KE, Mrs KF, Ms KG, Master KH and Master KI**

506. I found that flexi-cuffs and later mechanical handcuffs should not have been applied to Mr KE or his 17 year old son Master KH during their removal from Wickham Point and that this was contrary to their rights under article 10 of the ICCPR (and in Master KH's case under article 37(c) of the CRC) to be treated with humanity and with respect for their inherent dignity.

507. I found that the manner in which at least four masked ERT officers entered the bedroom of Ms KG, and refused her the opportunity to get dressed without them being present, was contrary to Ms KG's right to privacy under article 17(1) of the ICCPR.
508. Mr KE, Mrs KF, Ms KG, Master KH and Master KI are currently living in the community in Australia.
509. The extraction of the family from Wickham Point has had a significant impact on all of the members of the family. Mrs KF has been seeing a psychiatrist for at least two years, since April 2016, who has diagnosed her with post-traumatic stress disorder and a major depressive disorder of moderate severity. In a session with a psychologist at Foundation House in August 2015, shortly after the family had been released from detention on bridging visas, Mrs KF described the extraction from Wickham Point in the following way:
- [S]he and her family were taken from their rooms at 5am one morning after centre protests the day before. [Mrs KF] said that twenty men wearing helmets, muzzles and carrying shields entered her family's room and forcibly removed them all – including the children. She said that no one spoke to them or answered their questions and she felt terrified. ... The event and the days surrounding it were experienced as intensely disturbing for [Mrs KF].
- [Mrs KF] shows a range of effects associated with depression. She experiences overwhelming emotion and tears in session and makes regular expressions of hopelessness. She reports feeling shattered, like an earthquake has fallen on top of her, and that her early life has only ever contained adversity.
- [Mrs KF] is also showing effects associated with trauma. She experiences intrusive thoughts about events in Darwin, specifically when her son was handcuffed, when she was dragged along a corridor in her night clothes and when her husband [was] detained overnight at a police station. Contact with authority figures such as seeing Serco officers in a waiting room cause headaches, breathlessness and feelings of panic.
510. A counsellor from Foundation House also assessed Mr KE as having symptoms consistent with post-traumatic stress disorder including intrusive symptoms, dissociative symptoms, numbing panic, depressive mood and avoidance of traumatic memories. Mr KE said that the incident in which he was handcuffed mirrored the arbitrary arrest that he faced in Iran but said that one difference here was the humiliation of being handcuffed in front of his family.
511. Master KI has also continued to receive counselling from Foundation House during the three years since the family was released from immigration detention. In a session in June 2015, when he was 10 years old and the family was still in detention at MITA, he spoke about his father and brother being handcuffed during the Wickham Point extraction and that he and his mother were not told why or what was happening. He described being scared. He said that he still felt scared by the presence of security guards, electric doors and buzzers. The Foundation House counsellor concluded:
- [Master KI] experiences recurrent and distressing memories and nightmares of these events. The detention environment further triggers these traumatic memories on a daily basis.
- [Master KI] experiences a persistent negative emotional state and is unable to experience any positive emotions. He has lost motivation and displays suicidal ideation without intent. He has poor appetite and weight loss. [Master KI] also suffers nightly from enuresis.

512. Like her younger brother, Ms KG also received counselling from Foundation House in June 2015 and from May 2017. On a number of occasions she described to counsellors 'feeling paralysed by fear' when several officers entered her bedroom early in the morning of the Wickham Point extraction. She described often waking up in this 'frozen' state and that she continues to feel humiliated by this incident. She said that she remains fearful of men in uniform such as security officers and police.
513. During an assessment with Foundation House counsellors in June 2015, Master KH said that the experience of being separated from his distressed mother, sister and younger brother had a severe impact on him. He reported suffering from irritability, broken sleep, enhanced startle response and low mood.
514. I accept that the way in which this family was removed from Wickham Point during the pre-dawn operation on 18 April 2015 had a significant and ongoing impact on their mental and physical health. I accept that this impact resulted not only from how they were individually treated themselves, but also from their experiences of how their family members were treated.
515. In response to my preliminary view, the family sought recommendations that the Australian Government make a formal apology to the family and that it provide monetary compensation to affected members of the family.
516. I recommend that the Commonwealth pay the family an appropriate amount of compensation to reflect the loss and damage they have suffered as a result of the breaches of their human rights identified in the course of this inquiry.
517. In cases dealing with remedies for discrimination, courts have taken different views about whether it is appropriate to order a respondent found to have engaged in discrimination to apologise.<sup>93</sup> Under the Legal Services Directions 2017 (Cth), the Commonwealth is expected to behave as a model litigant in the conduct of litigation. This obligation extends to apologising where the Commonwealth is aware that it has acted wrongly or improperly.<sup>94</sup> This inquiry is not litigation, and I do not have power to compel an apology by the Commonwealth. But I consider that an apology is a remedy that I may recommend.
518. I consider that the treatment of this family warrants an apology from the Commonwealth. I recommend that such an apology be made.
519. The family also made a range of systemic recommendations. I have taken these into account in formulating the recommendations in the following sections.

**(h) Ms LC and her family**

520. I found that Ms LC was handcuffed for an hour and 40 minutes while being transferred from the detention facility to the police watch-house along with a number of other detainees; that she was separated from her husband and baby for 32 hours; and that she was denied the ability to speak with a lawyer. I found that this treatment of Ms LC was contrary to her rights under article 10 of the ICCPR to be treated with humanity and with respect for her human dignity, and with the rights of her baby daughter under article 9 of the CRC not to be separated from her mother.

521. Ms LC and her family are currently living in the community in Australia.
522. Ms LC has seen counsellors at Foundation House since being transferred to MITA in April 2015 and continued seeing these counsellors after being released from held detention in January 2016. Her counsellors have assessed Ms LC as presenting with symptoms consistent with post-traumatic stress disorder and a major depressive disorder. Her counsellor reports that:
- Her depressive symptoms appear to have commenced in Iran and intensified over her long period of immigration detention and are being maintained by uncertainty about her family's current situation and future.
- [Ms LC's] psychosocial functioning appears to have deteriorated enormously whilst in held detention. Whilst there is some improvement in her functioning after her release from held detention, she remains highly vulnerable to further mental health deterioration.
523. The Wickham Point extraction was one of a number of significant events during Ms LC's period of detention identified as contributing to her poor mental health.
524. In response to my preliminary view, Ms LC sought recommendations that the Australian Government make a formal apology to her family and that it provide monetary compensation to affected members of the family.
525. I recommend that the Commonwealth pay the family an appropriate amount of compensation to reflect the loss and damage they have suffered as a result of the breaches of their human rights identified in the course of this inquiry. I also consider that the treatment of Ms LC and her baby daughter warrants an apology from the Commonwealth. I recommend that such an apology be made.
526. The family also made a range of systemic recommendations. I have taken these into account in formulating the recommendations in the following sections.

**(i) Mrs MD and Mr ME**

527. I found that the use of flexi-cuffs and mechanical restraints on Mr ME was not appropriate in the circumstances and was contrary to his rights under article 10 of the ICCPR to be treated with humanity and with respect for his inherent dignity.
528. Mrs MD and Mr ME are currently living in the community in Australia.
529. Mr ME did not have any history of abusive, aggressive or violent behaviour. He had only recently been returned to immigration detention after five weeks as an intensive psychiatric inpatient in a private hospital. At the time of the extraction of families from Wickham Point, his diagnosis was of a schizoaffective disorder, bipolar type. I am not satisfied that his mental health issues were sufficiently taken into account during the extraction. I accept that the use of handcuffs on him in these circumstances was likely to be distressing.

530. I recommend that the Commonwealth pay to Mr ME an appropriate amount of compensation to reflect the loss and damage he has suffered as a result of the breaches of his human rights identified in the course of this inquiry.

### **Recommendation 1**

In order to remedy or reduce the loss or damage suffered by the six individual complainants and three family groups who I have found suffered detriment as a result of identified breaches of their human rights, the Commission recommends that:

- (a) The Commonwealth pay to Mr AY, Mr CE, Mr DB, Mr EJ, Mr FE, Mr KE and his family, Ms LC and her family and Mrs MD and her family an appropriate amount of compensation to reflect the loss and damage they have suffered as a result of the breaches of their human rights identified in the course of this inquiry.
- (b) The Commonwealth provide a formal apology to Mr KE and his family and to Ms LC and her daughter for the breaches of their human rights identified in the course of this inquiry.

## 12.2 Security risk assessments

531. Section 6 of this report deals with the development of security risk assessment tools by the department and Serco. The Commission's ability to interrogate these tools during the course of this inquiry has been limited because the department has refused to provide the Commission with certain information including:

- the audit relating to security risk assessments conducted by an external consultant in 2012
- the recommendations made by Serco to amend the security risk assessment tool in 2013
- the guidance provided by the department to Serco in 2015 about cohorts of detainees who should be categorised as 'high risk'
- a copy of the Security Risk Assessment Tool as amended in 2015.

532. Nevertheless, I have been able to form some judgements about how security risk assessments are carried out.

533. I am concerned about the default position which treats all physically fit single adult detainees as high risk for 28 days, regardless of their personal circumstances, unless the department has 'sufficient knowledge/information of the detainee to inform the risk assessment'. It is not clear how this initial risk assessment is conducted and what information is considered to be 'sufficient' in order to avoid a potentially arbitrary use of handcuffs. It appears that this policy is still likely to result in the use of restraints on people who ought to be categorised as low risk, for example if it is their first time in any form of detention. In my view, the default position should be that people are not restrained without proper justification.

534. The rationale used to justify this current position is not sufficiently supported by available data. While it is suggested by the department that this rule is necessary to prevent escapes from immigration detention, more than 30% of escapes are by people who have been in detention for more than seven months, and these are predominantly low and medium risk detainees. Further, the overall rate of escapes is low as a proportion of the number of people detained.
535. A more detailed investigation of the causes of escapes from detention is required in order to determine whether less restrictive measures can be applied to achieve the same objective. In my view, more justification is required for the imposition of a blanket application of restraints.

### **Recommendation 2**

The Commission recommends that restraints only be applied to a detainee where an individual assessment of their risk shows that this is warranted.

### **Recommendation 3**

The Commission recommends that the department instruct Serco to cease the practice of restraining all physically fit detainees for the first 28 days of their detention where Serco has not conducted an individual assessment of the detainee's risk that shows that the use of restraints is warranted.

### **Recommendation 4**

The Commission recommends that an independent investigation be undertaken into the circumstances leading to escapes from immigration detention and how these can best be prevented or reduced.

536. As noted above, the Commission has not been provided with a copy of the Security Risk Assessment Tool, however, the Commission has reviewed many examples of risk assessments produced by the tool. There are some general observations that the Commission has made based on its review of assessments. One of the most common categories of behaviour used is 'abusive/aggressive behaviour'. This covers a broad range of conduct including both bad language and conduct that is physically aggressive (but that does not amount to an assault). A count of incidents of this type is used as a data point when calculating a risk rating for 'aggression/violence' where the underlying conduct (eg bad language) may not have any element of physical aggression or violence. I consider that 'abusive' behaviour, if it is to be included in a risk assessment at all, should be separated from 'aggressive' behaviour and not be counted towards the risk of 'aggression/violence'.

537. I am concerned that this category is routinely used for very minor incidents and that accumulation of a number of these incidents can result in a more serious risk rating than may be warranted. For example, 17 year old Master KH had six incidents of 'abusive/ aggressive behaviour' on his risk assessment. They appeared to be predominantly about use of strong language rather than instances of physical aggression. Descriptions of his behaviour included: 'swearing at officers', 'shouting at Serco staff member' and 'shouting in a different language and invading into a staff member's personal space'. The only incident of physical violence that he had been involved in during 20 months of detention was reported as 'minor detainee assaulted officer by pushing officer's hands'. As a result of the accumulation of these incidents, his risk rating was medium. Any reasonable objective assessment of this teenager's conduct would not likely come to the conclusion that he was of 'medium' risk in a detention environment.
538. One way in which this problem could be addressed would be to remove 'abusive' behaviour from the SRAT altogether. On a day to day level, it appears that there also needs to be a more robust process for assessing whether incidents that are reported by Serco officers warrant inclusion on a person's risk assessment. Too often, very minor incidents make their way onto a person's security record.
539. A related problem is that once incidents are recorded on the SRAT, they stay there. It appears that this would have the effect of increasing a person's risk rating over time. A higher weighting is given to incidents that occurred in the last 3 months, so if a person is incident free for 3 months their risk rating may temporarily drop. However, even if a person is incident free for 3 months, it appears that their rating can only ever drop to the accumulated total of the incidents that are more than 3 months old. It does not appear that there is any process by which incidents that occurred a significant period of time ago are eventually removed from a risk rating. If this is correct, then those who are in detention for longer will almost inevitably have higher risk ratings than those who are there for a shorter period of time, even if the frequency with which they are involved in incidents is the same. The result would be that, in general, the longer a person is in detention, the more restrictive the environment will become as conditions are adjusted to a worsening risk rating. Some detainees are in immigration detention for many years. I consider that the SRAT should include a process by which older incidents can be removed from a person's risk assessment.
540. Finally, there are some applications of the SRAT that defy common sense. As described in paragraph 106 above, the Commission is aware of an incident where a person engaging in a 'peaceful sit down protest' against a decision refusing him permission to attend excursions had his activities recorded as a 'demonstration'. This was then a substantial factor in him receiving a 'high' escort risk rating, disqualifying him from participating in excursions. It is a perverse result that a person can be disqualified from attending excursions because of a peaceful protest against an earlier decision that he not be permitted to participate in excursions. There needs to be a process for reviewing whether the mechanical application of the SRAT is leading to inappropriate results. In my view, it would be preferable if this process permitted substantial amendment of a person's risk assessment where incidents had been improperly recorded, rather than just relying on a manual override by the centre Superintendent.



541. The department said that it was undertaking a joint review of the SRAT in conjunction with Serco. It said that this review would take into consideration recommendations made by external scrutiny bodies including the Commission. In order to ensure public confidence in this process, I recommend that the results of the joint review be made public.
542. Since receiving my preliminary view in this inquiry, the department has said that it has also commissioned an independent review of the SRAT to be conducted by an external consultant. I welcome this review and recommend that the external consultant be provided with a copy of my report so that the consultant can take into account the human rights concerns identified during the course of this inquiry. I also recommend that the report of the independent review by the external consultant be made public.

### **Recommendation 5**

The Commission recommends that in the department's joint review of the Security Risk Assessment Tool (SRAT) with Serco, and in the independent review of the SRAT being conducted by an external consultant, the following issues be considered:

- (a) separating incidents of 'abusive' behaviour from incidents of 'aggressive' behaviour
- (b) removing incidents of 'abusive' behaviour from inclusion in the SRAT altogether
- (c) incorporating a review process for assessing whether incidents are sufficiently material for inclusion on a person's risk assessment, and for removing incidents from a person's risk assessment that are not sufficiently material
- (d) incorporating a process for removing older incidents from a person's risk assessment.

### **Recommendation 6**

The Commission recommends that a copy of this report be provided to the external consultant engaged by the department to conduct an independent review of the SRAT, so that the human rights concerns identified in this report can be taken into account in that review.

### **Recommendation 7**

The Commission recommends that the department publish the results of the joint review of the SRAT it is undertaking with Serco and the report of the independent review of the SRAT being undertaken by an external consultant.

## 12.3 Use of force within detention centres

543. Section 4 of this report describes the legal framework for the use of force in immigration detention centres at times relevant to the case studies dealt with in this report.
544. Among other things, the contract between the department and Serco required that force only be used as a measure of last resort, when all other methods have failed or been assessed as inadequate, and then only with the reasonable level of force necessary in the circumstances. Incidents of use of force must be recorded in an incident report. The department recognises that it has a duty of care to detainees and that international human rights standards are important in determining the standard of care that detainees should receive.
545. The department says that its 'use of force' policy and instructions were comprehensively reviewed in 2016 and again in early 2017 while the Commission's inquiry was in progress. However, in response to a request from the Commission, the department refused to provide the Commission with a copy of these revised policies. The Commission's recommendations have therefore taken the department's policies as at 2015 as its starting point.
546. I welcome the recognition by the department that there has been a need to review its use of force policy and instructions. I have recommended above that the results of these review processes be made public. I also consider that there is a need to open up the review processes to public scrutiny and independent evaluation. This could best be done by way of a public inquiry by the department in which it invites comment on the framework for risk assessment and use of force in immigration detention.

### **Recommendation 8**

The Commission recommends that, following the publication of the reviews of the SRAT, the department conduct a public inquiry in relation to risk assessment and the use of force in immigration detention.

547. At a high level, the department's recognition of its duty of care to detainees and the contractual obligations imposed on the detention services provider Serco to ensure that force is not used unless as a measure of last resort are appropriate.
548. The issues that have arisen during the course of the Commission's inquiry have been about how force is used in practice.
549. It is important that there is an ongoing process to ensure that instructions relating to use of force are compliant with human rights standards, and that these instructions are complied with.

### **Recommendation 9**

The Commission recommends that the department develop a review process to ensure that:

- (a) all instructions relating to the use of force in immigration detention are regularly evaluated for compliance with international human rights standards, and
- (b) these instructions are being complied with.

550. It is also important that, when force is used, appropriate records are kept so that its use can be assessed for compliance with the legal framework. The best records of the use of force are video recordings. For pre-planned use of force, there should be no reason why the whole of the operation cannot be recorded on video with accompanying sound. However, on more than one occasion, the Commission has been provided with video recordings of use of force incidents that commence after the use of force has already started. In the case of Mr AY, the video recording commenced after the door to his room had already been broken down and he had already engaged in self-harm. In the Commission's *The Forgotten Children* inquiry, there were also significant problems in the operation of video equipment during a pre-planned use of force incident involving children detained on Christmas Island, including the video commencing after the incident had started, poor quality of filming and incomplete capture of the relevant incidents.<sup>95</sup>
551. In response to my preliminary view, the department said that 'updated policy and procedures address the record keeping gaps identified by the Commission ... including the requirement to video-record all pre-planned use of force incidents (where practicable)'. However, the department declined a request by the Commission to review these revised policies.

### **Recommendation 10**

The Commission recommends that:

- (a) any pre-planned use of force be video recorded from the start of the operation until its conclusion
  - (b) the video recording be carried out by a person trained to do so
  - (c) the recording be clear, include sound, and capture the entirety of the operation
  - (d) the requirement for recording and for the training of staff in recording be included in procedures manuals dealing with the use of force
  - (e) there be protocols for the storage and retention of video recordings so that they are available for any review of use of force incidents.
552. Emergency Response Team officers now routinely wear body cameras that can be activated during use of force incidents. However, the incident involving use of force on Mr HF shows that there are differences in how these cameras are used between different officers. There were two ERT officers involved in that incident. Video was provided to the Commission from the body camera of only one of the officers. That video was in three parts. There were gaps between the parts. The first part was just under 3 minutes long and stopped when Mr HF stood up. Based on the fixed CCTV footage, it is clear that there was then a gap of more than a minute before the start of the second part of the body camera footage. By this stage, the use of force on Mr HF had already commenced. The second part of the body camera footage lasted for 8 and a half minutes. In neither of the first two parts is the sound for the body camera video turned on. The third part starts once Mr HF is being led, compliantly, from the room after being handcuffed. This is the only part that has sound. The fixed CCTV camera in the room was able to capture the entire incident, but did not have sound.

### **Recommendation 11**

The Commission recommends that where detention centre staff such as Emergency Response Team officers are wearing body cameras:

- (a) the cameras are turned on throughout use of force incidents
- (b) they film continuously
- (c) the sound accompanying the video is turned on during the incident
- (d) these requirements are included in procedures manuals dealing with the use of force.

## 12.4 Use of handcuffs

### **(a) General principles**

553. The Commission has observed from its regular monitoring of immigration detention facilities that the use of restraints, particularly handcuffs, is becoming routine in transfers between immigration detention facilities and during escorts to external appointments such as medical appointments and court hearings.
554. The application of restraints in practice differs significantly from the impression generated by the department's Detention Services Manual. The manual suggests that use of handcuffs should be the exception, rather than the rule. In particular, the manual provides that 'restraint during escorted visits and scheduled travels only applies to detainees who have a serious or violent criminal history, those who have a history of escape, and those for whom the risk assessment indicates that they potentially pose a high risk'.
555. The key issue seems to be the ease with which detainees are given a 'high' risk assessment, thus requiring the use of handcuffs. As noted above, I am concerned about the default position that treats all physically fit single adult detainees as high risk for 28 days after entering detention. I am also concerned that some detainees are given a higher risk rating than a reasonable objective assessment would require.
556. People in immigration detention are in administrative detention. They are not serving a sentence of imprisonment and they are generally entitled to expect greater freedom of movement and personal liberty than prisoners. The use of restraints on immigration detainees should be limited to circumstances where this is reasonably necessary, based on an individualised risk assessment. It should not be a default setting for all or most detainees in the absence of a proper individualised assessment being made. As with the use of force more generally, the use of restraints should generally be a last resort and should be applied for the shortest appropriate period of time. It is important that these principles form part of the instructions given to officers responsible for making assessments about whether restraints should be applied.

**(b) United Kingdom experience**

557. It is instructive to consider how policies relating to the handcuffing of immigration detainees have been dealt with in the United Kingdom.
558. In the UK, the Chief Inspector of Prisons expressed concerns over a number of years about the practice of routine handcuffing of detainees attending appointments outside of immigration detention centres. In an inspection of Harmondsworth Immigration Removal Centre in 2011, the Chief Inspector noted that '[a]ll those going to outside appointments in the previous six months had been placed in handcuffs regardless of risk, and many had been handcuffed to an officer ("double cuffed")'.<sup>96</sup> A detailed risk assessment had been undertaken to identify the nature of any risks. In the 25 assessments examined by the Chief Inspector, 13 had been rated by the duty operational manager as low risk, unrestricted or not known, but all detainees in question had been handcuffed. The Chief Inspector described this practice as disproportionate and recommended that detainees should only be handcuffed during an escort if a risk assessment indicates a specific increased risk of escape or to the safety of the public or staff.<sup>97</sup>
559. The following year, the Chief Inspector reported on an inspection of Tinsley House Immigration Removal Centre. The report noted:
- Detainees escorted to hospital or other medical appointments were routinely handcuffed, and staff said it was customary for them to remain handcuffed to staff throughout medical procedures, or during an overnight stay in hospital. The decision was made by the duty director, and directions for staff to handcuff were recorded, though the risk assessments that we read were cursory.<sup>98</sup>
560. The Chief Inspector recommended that detainees should only be handcuffed for outside appointments, during medical assessments and other events on the basis of individualised and clearly documented risk assessments.<sup>99</sup>
561. A further inspection of Harmondsworth Immigration Removal Centre in 2013 revealed that the practice of routine handcuffing had continued. The failure to conduct proper individual risk assessments led to a number of shocking individual incidents. The Chief Inspector reported that:
- Those under escort had handcuffs applied, even when they had been assessed as low risk. A wheelchair-bound detainee had recently been handcuffed on a journey to a hospital for no obvious reason. We noted other cases of grossly excessive use of restraints during hospital escorts: in one, a dying man remained handcuffed while under sedation in hospital; in another, an 84 year-old man who had been declared unfit for detention was still in handcuffs at the point that he died. Neither had been in any way resistant or posed any current specific individual risk.<sup>100</sup>
562. The Chief Inspector reiterated, as the primary recommendation of the report, the previous recommendation that detainees not be routinely handcuffed during escorts or during hospital appointments.<sup>101</sup>

563. Following this report, a more proportionate approach to handcuffing was put in place by the Home Office and followed by the centre contractor.<sup>102</sup> In a report of an inspection of Harmondsworth site in 2015, the Chief Inspector noted that there had been a significant change in practice and that the primary recommendation had been partially achieved.<sup>103</sup> Now, 'individual risk assessments were appropriately informed by detainees' recent custodial behaviour' and '[d]etainees were not routinely handcuffed on escorts'.<sup>104</sup>
564. Several recent reports for a number of other UK immigration detention centres emphasised that detainees were no longer required to be handcuffed routinely on escorts.<sup>105</sup> However, the improvements have not been consistently applied. In a 2017 report in relation to Harmondsworth site, the Chief Inspector found that following an escape from immigration detention there had been 'a reversion to risk-averse handcuffing of detainees' and that they were 'once again being routinely handcuffed when attending outside appointments without evidence of risk'.<sup>106</sup>
565. The UK experience demonstrates the need for individual risk assessments that take into account the circumstances of the individual and the particular operation in which the use of restraints is being considered. It also shows the importance not only of establishing a framework for the proper use of restraints but also ensuring that this framework is applied in practice.

### **Recommendation 12**

The Commission recommends that the department's Detention Services Manual and the manuals for private detention service providers engaged by the department make clear that:

- (a) there is a presumption against the use of restraints, including handcuffs, during transfers between detention centres and during escorts to appointments
- (b) the use of restraints, including handcuffs, should be a measure of last resort
- (c) prior to each occasion when the use of restraints is proposed in relation to a detainee, there should be a new individualised risk assessment for that detainee in the context of the particular operation that takes into account:
  - (i) any general risk assessment prepared by the detention operator based on the relevant incidents that a detainee has been involved in while in immigration detention
  - (ii) the particular requirements of the operation, for example, a transfer between detention centres
  - (iii) whether that operation can be conducted safely without the need for restraints to be applied
- (d) the risk assessment should consider whether restraints should be applied during transit and, if so, at which point in the journey it may be appropriate to remove them
- (e) restraints should not be routinely applied to a particular class of detainees, including detainees generally assessed as being 'high' risk, without an individualised risk assessment of the kind described above being carried out

- (f) restraints should be used only for the shortest period of time necessary in the circumstances
- (g) the necessity for the continued use of restraints should be regularly re-evaluated during the course of an operation.

**(c) Use of restraints on children and vulnerable detainees**

566. I am concerned that handcuffs have been used on children and people with mobility impairments.
567. During the course of the Wickham Point extraction operation, flexi-cuffs were applied to 17 year old Master KH. At the time, his risk rating was medium. There is no evidence that Master KH was given the option of walking cooperatively with officers to the muster area. Rather, it appears that flexi-cuffs were applied at the first available opportunity.
568. During the same operation, flexi-cuffs were applied to two detainees who were using wheelchairs.

**Recommendation 13**

The Commission recommends that, consistently with the practice adopted in the United Kingdom, the department's Detention Services Manual and the manuals for detention service providers engaged by the department make clear that:

- (a) instruments of restraint should not be used on detainees who are under 18 years of age
- (b) there is a presumption against the use of restraints where a detainee's mobility is severely limited, for example when they are on crutches or using a wheelchair.

**(d) Approval to use of restraints when transporting groups**

569. If restraints are to be used on a particular person, the use of restraints on that person must be necessary. In some operations involving the transfer of a number of detainees between detention centres, restraints have been used on individuals whose personal circumstances did not warrant restraint. In some cases, people with low or medium risk ratings have been restrained only because they are being transferred with other detainees, some of whom may require restraint.
570. For example, when Mr CE was transferred from Christmas Island to Darwin via Melbourne he was restrained for the legs from Christmas Island to Melbourne despite having a risk rating of 'medium' but was not restrained for the onward leg from Melbourne to Darwin. The department sought to justify the use of restraints on him as necessary in the context of the operation as a whole where a number of other detainees were being transferred, some of whom (but not all) were also restrained. For the reasons set out earlier in this report, I am not satisfied that the use of restraints on Mr CE was necessary.

571. Similarly, in the case of the Wickham Point extraction, there was a general approval for the use of force and for use of restraints on all male detainees (including boys such as Master KH) regardless of whether their individual circumstances warranted the application of restraints. The use of restraints during this operation was indiscriminate. There was no individual consideration of the necessity of restraints for each of the people on whom restraints were applied. One result of the application of this general policy was that two men using wheelchairs were also restrained.

#### **Recommendation 14**

The Commission recommends that for each pre-planned use of force in the context of an operation involving more than one detainee, there is an individual assessment of the necessity for the use of restraints in relation to each detainee involved in the operation. There should be no presumption that a detainee should be restrained only because it is necessary to restrain another detainee.

#### **(e) Advice of medical practitioners**

572. Unlike equivalent guidelines in the UK, Australian guidelines about the use of restraints in immigration detention lack clarity about how to deal with situations where health professionals recommend that restraints not be applied. The department's contract with Serco imposes an obligation that Serco 'consult' with IHMS prior to the application of any planned use of force on a detainee. However, there do not appear to be any clear guidelines about how referrals to IHMS are to occur or about what to do once the advice is received.
573. For example, when Mr AY was handcuffed over a wrist wound, it does not appear from the medical records provided by the department that IHMS was asked for, or gave, advice about whether Mr AY should be handcuffed for transport. It appears that the decision to handcuff Mr AY had already been made by the time he was seen by IHMS. Further, it appears that the requirement to transport him meant that he was not provided with treatment recommended by IHMS. The medical notes say that IHMS was '[u]nable to give tetanus or antibiotics as client was cuffed and taken to the bus'.
574. On one occasion Mr DB was not medically cleared by IHMS prior to restraints being used to transport him to a court appointment because there were no IHMS staff on site.
575. On more than one occasion, medical notes record the views of IHMS officers that they have no control or influence over the question of whether restraints are to be applied. For example, when issues arose in relation to Mr DB's refusal to be handcuffed to attend medical appointments, Mr DB's clinical notes record that his 'appointment will not be rescheduled until issue resolved between client and security unit'. No records were produced that indicate that advice was sought by Serco from IHMS about the seriousness of Mr DB's condition or the necessity of the medical treatment sought. Later notes from a treating medical practitioner record a conversation with Mr DB in which the medical practitioner said: 'I explained that IHMS has no control over operational security procedure of Serco and my understanding is that he is considered high risk by Serco'. In a latter note a medical practitioner explained to Mr DB that the requirement that restraints be applied to him 'is not under the control or influence of IHMS'. I am concerned that there do not appear



to be any documents that record a consideration of whether the requirement that Mr DB be restrained was appropriate given the medical risks that he faced if he was not provided with the treatment recommended by his doctors. That is, the medical risks faced by Mr DB do not seem to have been a consideration in the decision to require him to wear restraints.

576. I consider that it is important that, in the ordinary course, the advice of medical practitioners about the use of restraints is both sought and acted upon. In this regard, I consider that the protocol developed by the UK Home Office in its August 2016 Detention Services Order provides a useful model.
577. I am also concerned at what appears to be a common practice of asking detainees who refuse to be handcuffed to attend medical appointments outside of the detention facility to sign a form that says that they have 'refused treatment'. Several detainees have refused to sign such forms on the basis that they want treatment but refuse to be handcuffed in order to receive it. This was the case for both Mr Abdellatif and Mr DB. It is also a common issue raised by detainees interviewed by the Commission during the course of inspections of immigration detention facilities. I consider that in such cases these forms do not accurately reflect the views of the detainees and that it is therefore not appropriate to ask them to sign forms of this nature.

### **Recommendation 15**

Subject to recommendation 16 below, and consistently with the practice adopted in the UK, the Commission recommends that the department's Detention Services Manual and the manuals for detention service providers engaged by the department make clear that:

- (a) the Detention Service Provider must consult with the Detention Health Services Provider prior to the application of any planned use of force against a detainee
- (b) if the Detention Health Services Provider advises that there are medical reasons for restraints not to be used on a detainee, then restraints should not be used on that detainee
- (c) a healthcare professional may direct the removal of restraints in certain circumstances, for example if:
  - (i) there is an immediate risk to the health of the detainee
  - (ii) the detainee is in pain or discomfort
  - (iii) the restraints are impeding treatment, clinical examination or ongoing clinical monitoring
- (d) a direction from a healthcare professional for restraints to be removed must be considered as a matter of urgency
- (e) if a healthcare professional directs the removal of restraints because of an immediate risk to the health of the detainee, then the restraints must be removed
- (f) if a healthcare professional directs the removal of restraints because they are impeding examination or treatment, the restraints must be removed.

### **Recommendation 16**

The Commission recommends that the department develop a protocol to be followed when there is a dispute between escort staff and medical practitioners about whether restraints are to be used on a detainee. That protocol may include the sharing of risk assessment information with medical practitioners on an informal basis and paths for the escalation of the dispute to more senior detention services and medical officers.

#### **(f) Record keeping**

578. It is important that proper records are kept in relation to every use of force incident to allow scrutiny of whether the use of force was appropriate in the circumstances. The complaints considered in this report have revealed a number of poor record keeping practices.
579. The process of seeking approval for the use of restraints should be seen as a substantive requirement for pre-planned use of force. It should not be seen merely as a formality, nor should the outcome of the request be presumed. I am concerned that, in some instances, pre-planned use of restraints occurred prior to approval for the use of restraints being received. For example, on two occasions Mr DB was restrained on escort prior to approval for the use of restraints being received. Similarly, the only record of approval provided to the Commission authorising the use of restraints on Mr AY was sent 3 and a half hours after he had been removed from his room and handcuffed.
580. There does not appear to be any formal system of record keeping relating to requests to IHMS for advice, or to advice provided by IHMS, in relation to the use of force or restraints. For example, when Mr AY was handcuffed over a wrist wound, medical notes indicate that IHMS was aware of this requirement but there is no record of a doctor being asked for an opinion as to whether or not this was appropriate.
581. As noted above it does not appear that the advice of IHMS was sought about whether or not Mr DB should be restrained in order to attend external medical appointments.
582. There were also examples where records were not available about instructions from the captain of an aircraft in relation to the use of restraints during a flight. Serco's Operational Safety Manual provides that the use of restraints on a detainee while travelling on a commercial aircraft 'will only be undertaken on the authority of the aircraft captain/ commander'. However, there were no records indicating that the captain of the flight transporting Mr AY required him to be handcuffed during the flight. Similarly, there were no records indicating that the captain of the flights transporting Mr CE from Christmas Island to Perth and from Perth to Melbourne required him to be handcuffed during the flight.

### **Recommendation 17**

The Commission recommends that pre-planned use of force, including use of restraints, not commence prior to approval for the use of force being received.

### **Recommendation 18**

The Commission recommends that the department develop a record keeping protocol to record:

- (a) the requests by the detention service provider to medical professionals; and
- (b) the advice received by the detention service provider from medical professionals

about whether force or restraints should be used on particular detainees. The Commission does not consider that it is sufficient for the detention service provider to rely on medical notes that merely observe that a client is to be handcuffed without a considered assessment of whether such restraint is appropriate.

#### **Recommendation 19**

The Commission recommends that the department develop a record keeping protocol to record instructions from the captain of an aircraft carrying immigration detainees about whether or not the captain requires the detainees to be restrained during the course of the flight.

## 12.5 Use of masks and spit hoods

583. I am concerned that the department has apparently authorised the use of spit hoods on detainees in circumstances where Serco officers were not provided with any training in their use, including in assessing whether or not the use of a spit hood is appropriate. The department was unable to produce any policies, procedures, guidelines or training documents about the use of spit hoods.

#### **Recommendation 20**

The Commission recommends that if spit hoods are to remain an approved means of restraint, that the department develop policies, procedures, guidelines and training documents about the circumstances in which spit hoods may be used. Such materials should recognise that this is a method of restraint that is degrading and that spit hoods should not be used otherwise than in exceptional circumstances where their use is clearly necessary, for example to protect the safety of others.

## 12.6 Transfers between detention centres

584. As part of the Commission's regular monitoring of immigration detention facilities, it has spoken with a number of detainees who expressed concern about the manner in which they were transferred between detention facilities. Some detainees reported that they were woken in the early hours of the morning, were given little or no time to pack their belongings and did not have the opportunity to notify family members, friends or legal representatives before they were transferred. Some claimed that they been given little or no prior warning of transfers or were not informed of the reason for the transfer.<sup>107</sup>
585. These concerns are also reflected in the experiences of the families involved in the Wickham Point extraction. The operation was conducted before dawn, the families were not given prior notice of the transfer and Ms LC's request to contact a lawyer was refused. In relation to the question of notice, the department said that the case of the Wickham Point extraction 'operational security requirements ... over[rode] detainee notification requirements'.

586. In the case of Mr AY's temporary transfer from Sydney to Perth, he says that he was not given any explanation for the transfer.
587. While there may be some cases where transfers between different immigration detention centres need to be conducted without prior notice, the Commission considers that these cases should be considered exceptional, particularly because detainees are being transferred from a secure detention environment.

### **Recommendation 21**

The Commission recommends that where a person is being transferred between immigration detention facilities, the department and facility staff should ensure as far as possible that the person:

- (a) is given adequate notice of the transfer
  - (b) receives a clear explanation of the reasons for the transfer
  - (c) is given an opportunity to dress and pack their belongings and notify family members, friends and legal representatives.
588. There are some aspects of the Wickham Point extraction that are a cause for concern. Broadly, these relate to:
- the degree of consideration given to the use of force as part of the planning of the operation
  - the separation of family members during the operation
  - the nature of the display of force during the operation and whether this was appropriate given the cohort of detainees which predominantly comprised families.
589. This extraction was a pre-planned use of force. The plan involved removing 19 detainees from Wickham Point and transferring them to Melbourne. There were detailed planning documents prepared by Serco, including an Operational Concept and a tactical plan. The documents assumed that force would be used and recognised that authorisation for the use of force would be required. However, these documents did not include an individual assessment of whether it was appropriate for restraints to be used on each of the 19 people to be removed.
590. There was no consideration of whether any of the 19 people to be extracted had particular vulnerabilities that meant that the use of restraints would not be appropriate. For example, it appears that Mr ME's mental health issues and Ms LC's medical conditions were not taken into account before the decision to handcuff each of them.
591. The approval granted for the use of force was given in the most general of terms. It was by email the evening prior to the operation and said '[a]pproval for the use of force and mechanical restraints is approved as required for the Saturday morning demonstration'.

592. I have found that restraints were used on some detainees where this was not warranted in the circumstances. This could have been avoided if there had been an individual assessment during the planning stage of the necessity for restraints to be used on each of the detainees.

### **Recommendation 22**

The Commission recommends that where there is a pre-planned use of force involving more than one detainee:

- (a) the planning documents for the operation consider whether force or restraints are necessary in relation to each detainee
  - (b) authorisation is separately obtained for the use of force or restraints in relation to each detainee.
593. The Wickham Point extraction involved the transfer of a number of family units. In a number of cases, children were separated from their parents. The most significant of these separations involved Ms LC who was separated from her new born baby and her husband for 32 hours. Ms LC was distressed at being physically separated from her baby and was concerned that her baby was missing out on breast milk during the period that they were separated.
594. Nine year old Master KI was taken from his room before dawn, separated from his parents and walked through corridors filled with heavily armoured ERT officers and other Serco officers to the muster area before being reunited with his mother on the bus to Bladin. While his separation from his parents was only temporary, it is likely to have been traumatic and there has been no clear explanation for why it was necessary.

### **Recommendation 23**

The Commission recommends that when transfers involve family units, the department and facility staff should ensure as far as possible that families are not separated during the transfer. If it is necessary for family members to be temporarily separated, they should be promptly informed of the location of the other members of their family and when they will be reunited.

595. I have earlier described the nature of the display of force during the Wickham Point extraction. It had the appearance of a paramilitary operation, involving more than 20 ERT officers in body armour, helmets and balaclavas some of whom were carrying large plastic shields; approximately 30 other Serco officers; and 34 or 35 police officers. In my view, the nature of the extraction operation was not appropriate in the circumstances. The compound in which the operation took place was a low security family compound. There were 19 people, mostly women and children, in around six family groups to be removed. For children such as 9 year old Master KI, I have no doubt that this was a highly distressing incident. Moreover, reactions of distress and fear were predictable outcomes of the nature of this operation. Subsequent evidence indicates that the operation had a traumatic and continuing impact on Mrs KF and her daughter Ms KG.
596. It appears highly likely that the operation could have been conducted in a less heavy handed manner without any additional safety concerns.

### **Recommendation 24**

The Commission recommends that when planning operations involving the transfer of family groups in immigration detention, more consideration be given to the impact that the nature of the operation is likely to have on vulnerable detainees. In particular, more consideration should be given to whether the display of force involved in the operation is likely to be disturbing for children. In those cases, modifications should be made to the operation to reduce the adverse impacts on them.

## 13 The department's response to my findings and recommendations

597. On 1 March 2019, I provided the department with a notice of my findings and recommendations.
598. On 2 April 2019, the department provided the following response to my findings and recommendations:

### **Recommendation 1**

*In order to remedy or reduce the loss or damage suffered by the six individual complainants and three family groups who I have found suffered detriment as a result of identified breaches of their human rights, the Commission recommends that:*

- (a) *The Commonwealth pay to Mr AY, Mr CE, Mr DB, Mr EJ, Mr FE, Mr KE and his family, Ms LC and her family and Mrs MD and her family an appropriate amount of compensation to reflect the loss and damage they have suffered as a result of the breaches of their human rights identified in the course of this inquiry.*
- (b) *The Commonwealth provide a formal apology to Mr KE and his family and to Ms LC and her daughter for the breaches of their human rights identified in the course of this inquiry.*

### **Response**

The Department does not accept the Commission's recommendations provided in parts (a) and (b) of this recommendation.

While we note the findings of the Australian Human Rights Commission dated 1 March 2019, it is the Department's position that compensation is only paid on the basis of potential legal liability where there is a meaningful prospect of liability. The Department does not accept that there is a meaningful prospect of legal liability in relation to the circumstances provided in the findings.

Further, compensation is only paid under the Compensation for Detriment caused by Defective Administration (CODA) scheme where the Department was defective in its administration and this resulted in a financial detriment, as outlined in Resource Management Guide 409 (the guide). The Department is of the view that no compensation is payable under the guide in relation to these complaints.

Accordingly, the Department remains of the position that no compensation is payable and a formal apology is not required.

## **Recommendation 2**

*The Commission recommends that restraints only be applied to a detainee where an individual assessment of their risk shows that this is warranted.*

### **Response**

The Department notes the Commission's recommendation as this requirement has been clarified in the most recent update to the operational policy instruction '*Detention Services Manual – Safety and security management – Use of force*' which came into effect on 10 January 2019.

Under departmental operational policy, the pre-planned use of force, including application of restraints, may only be applied to a detainee where an individual assessment of their risk shows that it is warranted and the relevant Australian Border Force (ABF) Detention Superintendent has provided written approval for such force to be used in the particular circumstances and prior to that force being applied.

## **Recommendation 3**

*The Commission recommends that the department instruct Serco to cease the practice of restraining all physically fit detainees for the first 28 days of their detention where Serco has not conducted an individual assessment of the detainee's risk that shows that the use of restraints is warranted.*

### **Response**

The Department does not accept the Commission's recommendation.

The Department continues to accept that there is an inherent safety and security risk to themselves, other detainees and/or the community stemming from a lack of knowledge of any person who has been in detention for less than 28 days. Where information is not available to the ABF or its service providers to indicate a detainee presents or poses a low risk, that individual can be considered high risk. The Department notes that this operational policy does not apply to adults who are accompanying children or have physical impairments that would prevent them from escaping, or causing harm to themselves or others.

In addition, the Department's use of force in immigration detention is extensively documented and governed by the *Migration Act 1958*, as well as detention operational policies and procedures, including the requirement for each pre-planned use of force to be approved by the ABF Detention Superintendent on a case-by-case basis.

## **Recommendation 4**

*The Commission recommends that an independent investigation be undertaken into the circumstances leading to escapes from immigration detention and how these can best be prevented or reduced.*

### **Response**

The Department does not accept the Commission's recommendation.

The Department is satisfied that current incident review mechanisms adequately provide assurance of the Department's incident response and management procedures. This includes the requirement, following an escape, for the ABF to lead debriefings with stakeholders and the Facilities and Detainee Services Provider (FDSP) to complete a Post Incident Review (PIR). The Department carefully considers recommendations arising from PIRs and where appropriate, implements changes to policies and procedures such as the changes made following the FDSP's 2013 review into escapes. In addition, all escape incidents are referred to the Department's Audit and Assurance Branch, providing a second line of assurance of the Department's processes. As with PIRs, Audit and Assurance Branch recommendations are carefully considered by the Department and where appropriate, amendments to policies and procedures are made.

The Department also notes that escape incidents have significantly lowered since the 2013/2014 financial year.

#### **Recommendation 5**

*The Commission recommends that in the department's joint review of the Security Risk Assessment Tool (SRAT) with Serco, and in the independent review of the SRAT being conducted by an external consultant, the following issues be considered:*

- (a) *separating incidents of 'abusive' behaviour from incidents of 'aggressive' behaviour*
- (b) *removing incidents of 'abusive' behaviour from inclusion in the SRAT altogether*
- (c) *incorporating a review process for assessing whether incidents are sufficiently material for inclusion on a person's risk assessment, and for removing incidents from a person's risk assessment that are not sufficiently material*
- (d) *incorporating a process for removing older incidents from a person's risk assessment.*

#### **Response**

The Department notes the Commission's recommendations provided in parts (a), (b), (c) and (d) of this recommendation.

To ensure the Security Risk Assessment Tool (SRAT) is fit for current and future purpose, the Department has developed a clear scope of works and procured an external consultant to undertake the independent review of the SRAT.

The Department would like to clarify that while the Department and the FDSP will assist with the external consultant's review, the Department and the FDSP are not conducting a separate review of the SRAT.

#### **Recommendation 6**

*The Commission recommends that a copy of this report be provided to the external consultant engaged by the department to conduct an independent review of the SRAT, so that the human rights concerns identified in this report can be taken into account in that review.*

#### **Response**

The Department accepts the Commission's recommendation.

The Department will make the AHRC's report available to the external consultant procured to undertake the independent review of the SRAT; however, as per recommendation 5, the review team has been given a clear scope of review and this has been designed by the Department to ensure the review is fit for current and future purpose.



### **Recommendation 7**

*The Commission recommends that the department publish the results of the joint review of the SRAT it is undertaking with Serco and the report of the independent review of the SRAT being undertaken by an external consultant.*

#### **Response**

The Department does not accept the Commission's recommendation.

The Department will not be publishing the results of the independent review of the SRAT due to operational safety and security concerns.

### **Recommendation 8**

*The Commission recommends that, following the publication of the reviews of the SRAT, the department conduct a public inquiry in relation to risk assessment and the use of force in immigration detention.*

#### **Response**

The Department does not accept the Commission's recommendation.

A public inquiry is unnecessary as detention services provided in Australia continue to be subject to departmental and parliamentary scrutiny and accountability.

### **Recommendation 9**

*The Commission recommends that the department develop a review process to ensure that:*

- (a) all instructions relating to the use of force in immigration detention are regularly evaluated for compliance with international human rights standards, and*
- (b) these instructions are being complied with.*

#### **Response**

The Department notes the Commission's recommendations provided in parts (a) and (b) of this recommendation.

It is the Department's position that an effective review process is already in place.

The Department's Policy and Procedure Control Framework (PPCF) was introduced in 2015. It mandates a standardised approach for the development and maintenance of policy and procedural advice and direction, and outlines the key principles and guidelines. As part of the PPCF process, compliance of new and existing policy and procedure documents, with Australian domestic legislation and Australia's international obligations, is considered.

The Department will continue to review its policies in relation to use of force in immigration detention within the PPCF and ensure they comply with Australian domestic legislation and Australia's international obligations.

It is a contractual requirement that the FDSP Policy and Procedure Manuals (PPMs) are consistent (and support compliance) with departmental policy and instruction, and are consistent with relevant accepted industry best practice.

Department and FDSP officers also receive regular training to ensure officer compliance with existing operational policy instructions and compliance with any changes made as a result of regular reviews of policy and instructions.

### **Recommendation 10**

*The Commission recommends that:*

- (a) any pre-planned use of force be video recorded from the start of the operation until its conclusion*
- (b) the video recording be carried out by a person trained to do so*
- (c) the recording be clear, include sound, and capture the entirety of the operation*
- (d) the requirement for recording and for the training of staff in recording be included in procedures manuals dealing with the use of force*
- (e) there be protocols for the storage and retention of video recordings so that they are available for any review of use of force incidents.*

### **Response**

The Department notes the Commission's recommendations provided in parts (a), (b), (c), (d) and (e) of this recommendation, as these requirements:

- have been clarified in the most recent updates to the operational policy instruction '*Detention Services Manual – Safety and security management – Audio-visual recording*' which came into effect on 10 January 2019 and
- are requirements under the FDSP contract.

Under Departmental operational policy and the FDSP contract, the FDSP is obliged to undertake audio-visual (AV) recordings in a range of circumstances, including any pre-planned use of force. Officers using AV recording equipment must ensure the equipment is checked prior to use to ensure that it is in good working order and must be suitably trained to operate the equipment.

The recording of operational activity using handheld devices, body cameras and vehicle mounted devices include both visual and sound recording. Images captured on Closed Circuit Television (CCTV) equipment located within immigration detention facilities (IDF) will not include sound recording.

If an event, incident or activity that would ordinarily be subject to AV recording is not recorded due to equipment malfunction or human error, the Department must be notified and an explanation provided for the failure. A copy of the notes and any associated incident reports should also be attached to the detainee's file. If the recording stops or is interrupted, including a decision to suspend recording, or if the batteries require changing, an explanation must be given for the interruption and the length of the interruption. If a detainee is being filmed, the detainee should be afforded an opportunity to comment on whether anything occurred during the suspension of recording.

Where such AV recordings have been made, the FDSP is required within 24 hours of the recording to: produce an unedited copy of the recording; label the original and copy of the recording with the date and time of the recording, and the names of the people who appear in the recording and; provide a copy of the recording to the Department on request, in an appropriate file format as determined by the Department. The FDSP must maintain copies of all AV recordings (including digital records and surveillance camera records) in accordance with the *Archives Act 1983* and other contractual requirements.

### **Recommendation 11**

*The Commission recommends that where detention centre staff such as Emergency Response Team officers are wearing body cameras:*

- (a) *the cameras are turned on throughout use of force incidents*
- (b) *they film continuously*
- (c) *the sound accompanying the video is turned on during the incident*
- (d) *these requirements are included in procedures manuals dealing with the use of force.*

### **Response**

The Department notes the Commission's recommendations provided in parts (a), (b), (c) and (d) of this recommendation, as these requirements:

- have been clarified in the most recent updates to the operational policy instruction '*Detention Services Manual – Safety and security management – Audio-visual recording*' which came into effect on 10 January 2019 and
- are requirements under the FDSP contract.

The FDSP is obliged to AV record activities and incidents that it knows the Department would want to view or hear as evidence of the actions of service provider personnel.

The Body Camera System (BCS) is used by selected and appropriately qualified and experienced FDSP officers in IDFs. The BCS is worn in a designated AV vest, identified by a label on the vest to be carrying AV equipment. The vest and associated equipment is routinely used by members of the Emergency Response Team (ERT) in support of search activities, incident response and management. BCS must not be used during a strip search procedure.

Departmental operational policy instructions require that immediately prior to arrival at an incident or at the first available opportunity in the event of an incident, FDSP officers wearing BCS are to turn on the BCS to AV record the entire event. Officers are to ensure that all discussions and activities are recorded until the incident is concluded. These operational policy instructions are included in the Department's PPCF and are centrally available to all staff. It remains a contractual requirement that the FDSP's PPMs are consistent (and support compliance) with departmental policy and instruction, and are consistent with relevant accepted industry best practice.

### **Recommendation 12**

*The Commission recommends that the department's Detention Services Manual and the manuals for private detention service providers engaged by the department make clear that:*

- (a) *there is a presumption against the use of restraints, including handcuffs, during transfers between detention centres and during escorts to appointments*

- (b) *the use of restraints, including handcuffs, should be a measure of last resort*
- (c) *prior to each occasion when the use of restraints is proposed in relation to a detainee, there should be a new individualised risk assessment for that detainee in the context of the particular operation that takes into account:*
  - (i) *any general risk assessment prepared by the detention operator based on the relevant incidents that a detainee has been involved in while in immigration detention*
  - (ii) *the particular requirements of the operation, for example, a transfer between detention centres*
  - (iii) *whether that operation can be conducted safely without the need for restraints to be applied*
- (d) *the risk assessment should consider whether restraints should be applied during transit and, if so, at which point in the journey it may be appropriate to remove them*
- (e) *restraints should not be routinely applied to a particular class of detainees, including detainees generally assessed as being 'high' risk, without an individualised risk assessment of the kind described above being carried out*
- (f) *restraints should be used only for the shortest period of time necessary in the circumstances*
- (g) *the necessity for the continued use of restraints should be regularly reevaluated during the course of an operation.*

### **Response**

The Department notes the Commission's recommendation provided in parts (a), (b), (c), (d), (e), (f) and (g) of this recommendation.

The Department's operational policy instructions on use of force for immigration detention were most recently updated in 2018 and came into effect on 10 January 2019. These operational policy instructions are included in the Department's PPCF and are centrally available to all staff. It remains a contractual requirement that the FDSP's PPMs are consistent (and support compliance) with departmental policy and instruction, and are consistent with relevant accepted industry best practice.

These operational policy instructions make it clear that there is a presumption against the use of force, including application of restraints, and that the use of force and/or restraint should only be used as a measure of last resort and for the shortest amount of time possible. This applies to movements within an IDF, transfers between IDFs, and during transport and escort activities outside of IDFs.

The pre-planned use of force, including application of restraints, may only be applied to a detainee where an individual assessment of their risk shows that it is warranted and the relevant ABF Detention Superintendent has provided written approval for such force to be used in the particular circumstances and prior to that force being applied. When planning a transfer or other detention related operations, circumstances of individual detainees including the risk they pose individually and as part of a group, as well as the nature and location of the offsite activity, are taken into account in determining whether the use of reasonable force may be necessary in order to achieve a safe and secure operation. In circumstances involving more than one detainee, authorisation must be separately obtained for the use of force/application of restraints in relation to each detainee. In addition, there is no presumption that a detainee should be restrained only because it is necessary to restrain another detainee.

As the Commission is aware, an independent review of the SRAT has been commissioned to improve the assessment and management of unlawful non-citizens in immigration detention. The Department maintains that a detainee's overall risk profile, which is used to inform how a detainee is managed, is determined through an individual assessment of each detainee's circumstances and not routinely applied to a particular class of detainees. A detainee's individual security risk assessment must be reviewed and where appropriate, updated, on a monthly basis (minimum) or when events trigger the need to review a detainee's security risk. The security risk assessment is undertaken to determine the security risk a detainee poses to themselves or others and the safe and secure operation of the IDF and is used to inform the circumstances under which pre-approved use of force may be used.

If a detainee is restrained, an officer must conduct welfare checks at regular intervals and ensure, as far as possible and practicable, that the detainee's comfort and dignity is maintained and the detainee is safe while restraints are applied to them. It is the responsibility of the most senior officer present to remove restraints at the first reasonable and practicable opportunity as directed in the operational planning documentation. Once restraints are removed, the ABF Detention Superintendent is to be advised of the removal of the instrument of restraint as soon as is practicable.

All detention operations are conducted under the C3 Doctrine and Operational Planning Framework. The C3 Doctrine provides a clear management structure and system designed to effectively complete operational tasks, plan and conduct operations and respond to and resolve incidents. It also informs and guides how all operational activities are planned, coordinated, communicated and executed. The Operational Planning Framework is used in the planning and conduct of all ABF operations, including detention operations and aligns closely with the C3 Doctrine.

It is the Department's view that current operational policy instructions on the use of force for immigration detention, the security risk assessment process, supporting training programs and operational planning processes provide clear guidance and flexibility to departmental and FDSP officers, in the use of force, including application of restraints, on a case-by-case basis.

### **Recommendation 13**

*The Commission recommends that, consistently with the practice adopted in the United Kingdom, the department's Detention Services Manual and the manuals for detention service providers engaged by the department make clear that:*

- (a) instruments of restraint should not be used on detainees who are under 18 years of age*
- (b) there is a presumption against the use of restraints where a detainee's mobility is severely limited, for example when they are on crutches or using a wheelchair.*

### **Response**

The Department accepts in part the Commission's recommendation provided in part (a) and (b) of this recommendation. The Department does not accept the unconditional exclusion of using instruments of restraint on detainees under 18 years of age.

Officers must exercise care and informed decision making before using reasonable force and/or application of restraints on any detainee. However, vulnerable people, including minors, and the existence of certain qualities or factors, which are not always readily identifiable or demonstrated, may contribute to a detainee's behaviour. These may, in turn, affect the decision to use force and/or application of restraints and the manner in which it is used. The Department believes in some circumstances, it may be necessary, reasonable and proportionate to use force in these circumstances.

Use of force, including the application of restraints, must not be used on a minor unless an officer believes, on reasonable grounds, that it is essential to safely transport or protect the welfare and/or security of the minor or another person. The Department maintains that there may be circumstances where it is lawful, reasonable and appropriate to use force, including application of restraints, on a person under 18 years of age.

The FDSP must ensure that, whenever force is used on detainees that are frail, elderly or minors, officers take all reasonable precautionary measures to ensure the safety of the detainee that are appropriate to the circumstances of that detainee.

Where there is medical evidence that supports a detainee's mobility being severely limited, there will be a presumption against the application of restraints. This expectation is articulated in the updated operation policy instruction '*Detention Services Manual – Safety and security management – Use of force*' which came into effect on 10 January 2019.

The Department reiterates its advice of 2 July 2018 that in respect to the two detainees restrained whilst in wheelchairs during the Wickham Point Transfer Operation, there are no records to suggest that either had a medical condition for which the Detention Health Service Provider (DHSP) had recommended the use of a wheelchair during April 2015. While both men were observed to be seated in wheelchairs in the period preceding the operation, their use of those wheelchairs during the April 2015 transfer operation appear to have been based on the individual's personal preference, not for medical necessity.

#### **Recommendation 14**

*The Commission recommends that for each pre-planned use of force in the context of an operation involving more than one detainee, there is an individual assessment of the necessity for the use of restraints in relation to each detainee involved in the operation. There should be no presumption that a detainee should be restrained only because it is necessary to restrain another detainee.*

#### **Response**

The Department notes the Commission's recommendation as this requirement has been clarified in the most recent update operational policy instruction '*Detention Services Manual – Safety and security management – Use of force*' which came into effect on 10 January 2019.

Under departmental operational policy, the pre-planned use of force, including application of restraints, may only be applied to a detainee where an individual assessment of their risk shows that it is warranted and the relevant ABF Detention Superintendent has provided written approval for such force to be used in the particular circumstances and prior to that force being applied.

Where there is pre-planned use of force involving more than one detainee, the planning documentation for the operation must consider whether the use of force, including application of restraints, is appropriate and necessary in relation to each detainee on an individual basis. In this circumstance, authorisation must be separately obtained in relation to each individual detainee. In considering the individual circumstances of each detainee in the planning process, there should be no presumption that a detainee should be restrained only because it is necessary to restrain another detainee.

#### **Recommendation 15**

*Subject to recommendation 16 below, and consistently with the practice adopted in the United Kingdom, the Commission recommends that the department's Detention Services Manual and the manuals for detention service providers engaged by the department make clear that:*

- (a) *the Detention Service Provider must consult with the Detention Health Services Provider prior to the application of any planned use of force against a detainee*
- (b) *if the Detention Health Services Provider advises that there are medical reasons for restraints not to be used on a detainee, then restraints should not be used on that detainee*
- (c) *a healthcare professional may direct the removal of restraints in certain circumstances, for example if:
 
  - (i) *there is an immediate risk to the health of the detainee*
  - (ii) *the detainee is in pain or discomfort*
  - (iii) *the restraints are impeding treatment, clinical examination or ongoing clinical monitoring**
- (d) *a direction from a healthcare professional for restraints to be removed must be considered as a matter of urgency*
- (e) *if a healthcare professional directs the removal of restraints because of an immediate risk to the health of the detainee, then the restraints must be removed*
- (f) *if a healthcare professional directs the removal of restraints because they are impeding examination or treatment, the restraints must be removed.*

## **Response**

The Department notes the Commission's recommendation provided at part (a) of this recommendation and does not accept the Commission's recommendations provided in parts (b), (c), (d), (e), and (f) of this recommendation.

Under departmental operational policy, as well as the FDSP contract, the FDSP is required to prepare a risk analysis and consult with the DHSP to ensure that no medical reasons preclude the use of force, including application of restraints, on a detainee. In consulting with the DHSP, the FDSP must document the request for information from the DHSP, as well as any advice provided by the DHSP. Advice received from the DHSP must be included in the use of force approval request submitted to the relevant ABF Detention Superintendent.

The Department does not accept the Commission's recommendation that a health provider can direct or make a decision on the use of force, including application of restraints, in respect to detainees. Any concerns a health provider may have in relation to the use of force/application of restraints in relation to an individual detainee should be referred to the relevant ABF Detention Superintendent for consideration and decision. This is because there may be other relevant factors that should be considered in conjunction with the views of the healthcare provider for the use of force/application of restraints, such as the safety and/or security of the community or the detainee.

Where a detainee is restrained, an officer must conduct welfare checks at regular intervals and ensure, as far as possible and practicable, that the detainee's comfort and dignity is maintained and the detainee is safe while restraints are applied to them. It is the responsibility of the most senior officer present to remove restraints at the first reasonable and practicable opportunity and on a case-by-case basis as directed in the operational planning documentation. When restraints are removed, the ABF Detention Superintendent is to be advised of the removal of the instrument of restraint as soon as is practicable.

The Department undertakes to review its operational policy instructions to ensure officers have appropriate operational guidance in respect to the removal of restraints during transport and escort activities, including where concerns are raised by treating health care professionals.

#### **Recommendation 16**

*The Commission recommends that the department develop a protocol to be followed when there is a dispute between escort staff and medical practitioners about whether restraints are to be used on a detainee. That protocol may include the sharing of risk assessment information with medical practitioners on an informal basis and paths for the escalation of the dispute to more senior detention services and medical officers.*

#### **Response**

The Department does not accept the Commission's recommendation. Refer to response to Recommendation 15.

#### **Recommendation 17**

*The Commission recommends that pre-planned use of force, including use of restraints, not commence prior to approval for the use of force being received.*

#### **Response**

The Department notes the Commission's recommendation as this requirement was clarified in the updated operational policy instruction 'Detention Services Manual – Safety and security management – Use of force' which came into effect on 10 January 2019 and is included in the FDSP Contract.

#### **Recommendation 18**

*The Commission recommends that the department develop a record keeping protocol to record:*

- (a) the requests by the detention service provider to medical professionals; and*
- (b) the advice received by the detention service provider from medical professionals*

*about whether force or restraints should be used on particular detainees. The Commission does not consider that it is sufficient for the detention service provider to rely on medical notes that merely observe that a client is to be handcuffed without a considered assessment of whether such restraint is appropriate.*

#### **Response**

The Department notes the Commission's recommendations provided in parts (a) and (b) of this recommendation as this requirement was clarified in the updated operational policy instruction 'Detention Services Manual – Safety and security management – Use of force' which came into effect on 10 January 2019 and is included in the Immigration Detention Facilities and Detainee Services Contract.

In the instance of a pre-planned use of force, the FDSP is required to prepare a risk analysis and consult with the DHSP.

In consulting with the DHSP on a pre-planned use of force, including application of restraints, the FDSP must document the request for information from the DHSP, as well as any advice provided by the DHSP. Advice received from the DHSP must be included in the use of force approval request submitted to the relevant ABF Detention Superintendent.



In this regard, the relevant ABF Detention Superintendent must consider the information from the FDSP and any views submitted by the DHSP, including where there are divergent views, in order to make an informed decision about the use of force/application of restraints in respect to an individual detainee. This may include undertaking further consultation with the FDSP and/or DHSP. The Department reiterates that neither the FDSP nor the DHSP is the decision maker in relation to the pre-planned use of force/application of restraints.

### **Recommendation 19**

*The Commission recommends that the department develop a record keeping protocol to record instructions from the captain of an aircraft carrying immigration detainees about whether or not the captain requires the detainees to be restrained during the course of the flight.*

### **Response**

The Department notes the Commission's recommendation.

The Department's operational policy instruction 'Detention Services Manual – Detainee entry and exit – Transporting detainees by aircraft' prescribes that the FDSP Aircraft Escort Team Leader is responsible for recording any key events or incidents within the Escort Operational Order and ensuring that any conversations and/or decisions made by the aircraft captain are appropriately recorded.

### **Recommendation 20**

*The Commission recommends that if spit hoods are to remain an approved means of restraint, that the department develop policies, procedures, guidelines and training documents about the circumstances in which spit hoods may be used. Such materials should recognise that this is a method of restraint that is degrading and that spit hoods should not be used otherwise than in exceptional circumstances where their use is clearly necessary, for example to protect the safety of others.*

### **Response**

The Department accepts in-part the Commission's recommendation.

The Department agrees to ensure that its operational policy instructions and training documents, and those of the FDSP, relating to the use of spit hoods are current and reflect the circumstances in which they may be applied.

The Department maintains that spit hoods may be used within the immigration detention network, in exceptional circumstances, where there is a need to protect other detainees, staff, and others from the risk of being spat on or bitten.

The Safariland Tranzport Hood remains an approved type of restraint for use within the immigration detention network. The Department agrees to ensure that its policies, procedures, guidelines and training documents, and those of the Facilities and Detainee Service Provider, relating to the use of spit hoods are current and reflect the circumstances in which they may be applied.

As with all forms of restraint used in the immigration detention network, the Department requires that detainees will be treated fairly and reasonably within the law and to ensure the inherent dignity of the person.

### **Recommendation 21**

*The Commission recommends that where a person is being transferred between immigration detention facilities, the department and facility staff should ensure as far as possible that the person:*

- (a) is given adequate notice of the transfer*
- (b) receives a clear explanation of the reasons for the transfer*
- (c) is given an opportunity to dress and pack their belongings and notify family members, friends and legal representatives.*

### **Response**

The Department notes the Commission's recommendations provided in parts (a) and (c) of this recommendation and does not accept the recommendation provided in part (b) of this recommendation.

It is an operational policy requirement that once a recommendation to transfer a detainee within the immigration detention network (IDN) has been approved, the transfer should be carried out as soon as practicable.

Where appropriate, detainees should be advised of a decision to move them within the IDN during business hours and no later than the day prior to the day of the intended transfer. The onus of responsibility is on detainees to notify their representatives (or any other third party) of their move within the immigration detention network if they choose to do so.

It remains the Department's position that detainees will not routinely be given an explanation for the reason/s for their transfer within an immigration detention facility or the immigration detention network. To do so has the real potential of jeopardising the safety and good order of the immigration detention facility or immigration detention network.

In managing detainee property during transfers both within an IDF and the IDN, detainees are responsible for packing their own in-possession property. When transferring to another immigration detention facility, it is essential that detainees plan which possessions they include in their airline baggage allowance. If a detainee is being moved within the immigration detention network, the FDSP is responsible for packing any in-trust property. The detainee (owner) should inspect the in-trust property and sign the reconciliation property form. Any discrepancies must be referred to the FDSP Facilities Operations Manager.

If a detainee leaves an immigration detention facility suddenly, the FDSP is responsible for the storage, management and security of a detainee's personal property. Departure could be due to, but not limited to, escape, hospitalisation, and transfer within the immigration detention network or to a correctional facility for good order and security purposes.

Detainees can request information about why they were transferred to another IDF. The FDSP must inform detainees of their right to complain without hindrance or fear of reprisal. This includes the reason as to why they were transferred to another facility. Detainees can lodge a complaint through the detainee complaint forms located at the IDF.

### **Recommendation 22**

*The Commission recommends that where there is a pre-planned use of force involving more than one detainee:*

- (a) *the planning documents for the operation consider whether force or restraints are necessary in relation to each detainee*
- (b) *authorisation is separately obtained for the use of force or restraints in relation to each detainee.*

### **Response**

The Department notes the Commission's recommendations provided in parts (a) and (b) of this recommendation.

It is departmental operational policy that there is a presumption against the application of restraints, during planned operations, including transfers between immigration detention facilities and during transport and escort tasks outside of immigration detention facilities involving individual detainees or more than one detainee.

The pre-planned use of force, including application of restraints, may only be applied to a detainee where an individual assessment of their risk shows that it is warranted and the relevant ABF Detention Superintendent has provided written approval for such force to be used in the particular circumstances and prior to that force being applied. Where there is pre-planned use of force involving more than one detainee, the planning documentation for the operation must consider whether the use of force, including application of restraints, is appropriate and necessary in relation to each detainee on an individual basis. In this circumstance, authorisation must be separately obtained in relation to each individual detainee. In considering the individual circumstances of each detainee in the planning process, there should be no presumption that a detainee should be restrained only because it is necessary to restrain another detainee. These requirements were clarified in the most recent update to the operational policy instruction '*Detention Services Manual – Safety and security management – Use of force*' which came into effect on 10 January 2019.

This is consistent with the Department's earlier advice to the Commission that, when planning transfer or other detention related operations, circumstances of individual detainees, including the risk they pose individually and as part of a group, as well as the nature and location of the offsite activity, are taken into account in determining whether the use of reasonable force may be necessary in order to achieve a safe and secure operation.

### **Recommendation 23**

*The Commission recommends that when transfers involve family units, the department and facility staff should ensure as far as possible that families are not separated during the transfer. If it is necessary for family members to be temporarily separated, they should be promptly informed of the location of the other members of their family and when they will be reunited.*

### **Response**

The Department accepts the Commission's recommendation on this matter and undertakes to update its operational policy instructions to ensure that this expectation is clearly articulated. The Department expects that this will be completed by 30 June 2019.

### **Recommendation 24**

*The Commission recommends that when planning operations involving the transfer of family groups in immigration detention, more consideration be given to the impact that the nature of the operation is likely to have on vulnerable detainees. In particular, more consideration should be given to whether the display of force involved in the operation is likely to be disturbing for children. In those cases, modifications should be made to the operation to reduce the adverse impacts on them.*

### **Response**

The Department accepts the Commission's recommendation.

The security and good order of immigration detention facilities is vital in maintaining the safety of detainees, staff and visitors. The Department takes this role seriously and responds in the most direct and appropriate way to threats made by individuals who choose to engage in disruptive behaviour and potentially endanger themselves or others.

During operational planning, the ABF and the FDSP will take into account the physical environment, the nature of the activity, persons who may be present or in the vicinity of the operation and risks to be managed in order to ensure the safe and secure conduct of the operation. The actual operational response, including the resources deployed to undertake the operation, will be based on consideration of all these factors.

The Department's use of force policy and procedural instructions apply to the use of reasonable force on detainees held in immigration detention. Use of force is a measure of last resort and should not be used unless it is reasonably necessary to achieve a lawful outcome. Departmental staff and contractors must exercise care and informed decision making before using force against any person. The use of force must always be reasonable and departmental staff and contractors must consider the individual circumstances of any person against whom force is being considered, including vulnerable detainees, and must be aware of the distress that can be inflicted on a minor should they see their parent, guardian or any detainee being restrained.

599. I report accordingly to the Attorney-General.

A handwritten signature in black ink that reads "Rosalind Croucher". The signature is written in a cursive, flowing style.

Emeritus Professor Rosalind Croucher AM  
**President**  
Australian Human Rights Commission

May 2019

## Endnotes

- 1 The ICCPR is referred to in the definition of 'human rights' in s 3(1) of the AHRC Act. The CRC is an international instrument that has been declared under s 47 for the purposes of the AHRC Act.
- 2 See *Secretary, Department of Defence v HREOC, Burgess & Ors* (1997) 78 FCR 208.
- 3 UN Human Rights Committee, *General comment No. 21: Article 10 (Humane treatment of persons deprived of their liberty)*, at [3].
- 4 *Walker and Richards v Jamaica*, Communication No 529/1993, UN Doc CCPR/C/60/D/639/1995; *Kennedy v Trinidad and Tobago*, Communication No 845/1998, UN Doc CCPR/C/74/D/845/1998; *R.S. v Trinidad and Tobago*, Communication No 684/1996, UN Doc CCPR/C/74/D/684/1996.
- 5 [2007] NZSC 70.
- 6 [2007] NZSC 70, [79].
- 7 The Standard Minimum Rules were approved by the UN Economic and Social Council by its resolutions 663C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977. They were adopted by the UN General Assembly in resolutions 2858 of 1971 and 3144 of 1983; UN Doc A/COMF/611, Annex 1. At <http://www.ohchr.org/EN/ProfessionalInterest/Pages/TreatmentOfPrisoners.aspx> (viewed 18 March 2015).
- 8 The Body of Principles were adopted by the UN General Assembly in resolution 43/173 of 9 December 1988 Annex: UN Doc A/43/49 (1988). At <http://www.un.org/documents/ga/res/43/a43r173.htm> (viewed 18 March 2015).
- 9 UN Human Rights Committee, *General Comment 21 (Replaces general comment 9 concerning humane treatment of persons deprived of liberty)* (10 April 1992) at [5].
- 10 UN Human Rights Committee, *Mukong v Cameroon*, Communication No. 458/1991, UN Doc CCPR/C/51/458/1991 (1994) at [9.3]; *Potter v New Zealand*, Communication No. 632/1995, UN Doc CCPR/C/60/D/632/1995 (1997) at [6.3]. See also, UN Human Rights Committee, *Concluding Observations on the United States*, UN Doc A/50/40 (3 October 1995) at [285] and [299].
- 11 UN Human Rights Committee, *Wilson v Philippines*, Communication No. 868/1999, UN Doc CCPR/C/79/D/868/1999 (2003) at [7.3].
- 12 UN Human Rights Committee, *Cabal and Bertran v Australia*, Communication No. 1020/2001, UN Doc CCPR/C/78/D/1020/2001 (2003) at [7.2].
- 13 Australian Human Rights Commission, Report of an inquiry into a complaint by Mr AV of a breach of his human rights while in immigration detention [2006] AusHRC 35. At <http://www.humanrights.gov.au/publications/hreoc-report-no-35> (viewed 18 March 2015).
- 14 CRC, opened for signature 20 November 1989, [1991] ATS 4 (entered into force generally on 2 September 1990; entered into force for Australia on 16 January 1991).
- 15 The *United Nations Rules for the Protection of Juveniles Deprived of their Liberty* were adopted by the UN General Assembly in resolution 45/113 of 14 December 1990, UN Doc A/RES/45/113 (1990), Annex. At <http://www.un.org/documents/ga/res/45/a45r113.htm> (viewed 18 March 2015).
- 16 JDL Rules, rule 64.
- 17 UN Committee on the Rights of the Child, General Comment No. 10, *Children's rights in juvenile justice* (25 April 2007), UN Doc CRC/C/GC/10 at [89]. At [http://tbinternet.ohchr.org/\\_layouts/treatybodyexternal/Download.aspx?symbolno=CRC%2fC%2fGC%2f10&Lang=en](http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC%2fC%2fGC%2f10&Lang=en) (viewed 24 March 2015).
- 18 Australian Human Rights Commission, *Report of an inquiry into a complaint by Ms KJ concerning events at Woomera Immigration Reception and Processing Centre between 29-30 March 2002* [2004] AusHRC 27. At <http://www.humanrights.gov.au/publications/hreoc-report-no-27> (viewed 18 March 2015).
- 19 Australian Human Rights Commission, *Yousefi family v Commonwealth* [2011] AusHRC 46. At <http://www.humanrights.gov.au/publications/aushrc-46-yousefi-family-v-commonwealth-australia> (viewed 27 March 2015).
- 20 *Convention for the Protection of Human Rights and Fundamental Freedoms*, commonly referred to as the European Convention on Human Rights, opened for signature by the member States of the Council of Europe 4 November 1950, entered into force 3 September 1953.
- 21 *Raninen v Finland* (Appl. No. 152/1996), Judgment (Chamber), 16 December 1997, Reports 1997-VIII, at [55]-[56]; quoted with approval in *The Queen on the application of Vaclavos Faizovas (proceedings by Inga Faizovaite) v Secretary for State of Justice* [2009] EWCA Civ 373 at [3] (Arden LJ).
- 22 *Mouisel v France* (2004) 38 EHRR 34 at [47].
- 23 *Mouisel v France* (2004) 38 EHRR 34 at [47].
- 24 European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, *Factsheet on Immigration Detention*, March 2017, p 7. At <https://rm.coe.int/16806fbf12> (viewed 6 February 2018).
- 25 *R (Vary & others) v Secretary of State for the Home Department* [2004] EWHC 2251 at [82]. This case was determined on the basis of administrative law principles rather than human rights principles.
- 26 *FGP v Serco & Secretary of State for the Home Department* [2012] EWHC 1804 at [54].
- 27 *FGP v Serco & Secretary of State for the Home Department* [2012] EWHC 1804 at [54].
- 28 Migration Act, ss 189 and 196.
- 29 Allen Hawke and Helen Williams, *Independent Review of the Incidents at the Christmas Island Immigration Detention Centre and Villawood Immigration Detention Centre*, 31 August 2011 (Hawke-Williams Report), p 79. At <http://www.border.gov.au/ReportsandPublications/Documents/reviews-and-inquiries/independent-review-incident-christmas-island-villawood-full.pdf#search=hawke%20williams%20report> (viewed 19 April 2017).
- 30 Immigration Detention Facilities and Detainee Services Contract between the Commonwealth and Serco, 10 December 2014, Sch 2 (Statement of Work), Section 4 (Security Services), clause 1.1(b).
- 31 Immigration Detention Facilities and Detainee Services Contract between the Commonwealth and Serco, 10 December 2014, Sch 2 (Statement of Work), Section 4 (Security Services), clause 3.8.

- 32 Immigration Detention Facilities and Detainee Services Contract between the Commonwealth and Serco, 10 December 2014, Sch 2 (Statement of Work), Section 4 (Security Services), clause 3.10.
- 33 Department of Immigration and Border Protection, *Detention Services Manual – Chapter 1 – Legislative and principles overview – Duty of care to detainees* (July 2016) at [4].
- 34 Department of Immigration and Border Protection, *Detention Services Manual – Chapter 1 – Legislative and principles overview – Duty of care to detainees* (July 2016) at [5].
- 35 Department of Immigration and Border Protection, *Detention Services Manual – Chapter 1 – Legislative and principles overview – Duty of care to detainees* (July 2016) at [5].
- 36 Department of Immigration and Border Protection, *Detention Services Manual – Chapter 1 – Legislative and principles overview – Duty of care to detainees* (July 2016) at [7].
- 37 Department of Immigration and Border Protection, *Detention Services Manual – Chapter 8 – Safety and security – Use of reasonable force* (September 2015), p 3.
- 38 Department of Immigration and Border Protection, *Detention Services Manual – Chapter 8 – Safety and security – Use of reasonable force* (September 2015), p 4.
- 39 Australian Human Rights Commission, *Immigration detention reports* (2017). At <http://www.humanrights.gov.au/our-work/asylum-seekers-and-refugees/immigration-detention-reports-and-photos> (viewed 17 January 2019).
- 40 Department of Immigration and Border Protection, *Detention Services Manual – Chapter 8 – Safety and security – Use of reasonable force* (September 2015), p 6.
- 41 Department of Immigration and Border Protection, *Detention Services Manual – Chapter 8 – Safety and security – Use of reasonable force* (September 2015), p 7.
- 42 Department of Immigration and Border Protection, *Detention Services Manual – Chapter 8 – Safety and security – Use of reasonable force* (September 2015), p 6.
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